

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03622

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powder Mill (Balt)</u> c. LENGTH OF STAY IN 1b <u>6 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3447 Yorkway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Preble</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McARTHUR</u> d. STREET ADDRESS <u>RT. #1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WIRT</u> First Middle Last 4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>NOV 29, 1885</u> 9. AGE (In years last birthday) <u>70</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u> 11. BIRTHPLACE (State or foreign country) <u>W. VA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ZER ACORD</u> 14. MOTHER'S MAIDEN NAME <u>AGNETHA BROWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>29-3-18-2096</u> 17. INFORMANT <u>SON</u> Address <u>3447 Yorkway BALT 22</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Jack Collins</u> EXAMINER'S NAME (Type) <u>JACK E Collins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELK FORK</u>		22d. LOCATION (City, town, or county) (State) <u>McARTHUR OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Bradley, Hamilton, W. Va.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 17</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 17 1968

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3675

CERTIFICATE OF DEATH

03623
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>34 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> <u>Box 75</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>(NMT)</u> Last <u>AMERICA</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/89</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>6</u> Hours <u>0</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph America</u>			
14. MOTHER'S MAIDEN NAME <u>Jennie Smith</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>			
16. SOCIAL SECURITY NO. <u>212-32-2942</u>				17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY THROMBOSIS</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>March 6</u> , 19 <u>56</u> to <u>April 9</u> , 19 <u>56</u> that I last saw the deceased alive on <u>April 9</u> , 19 <u>56</u> and that death occurred at <u>3:35 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/10/56</u> ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. <u>VAH, Fort Howard, Md.</u> PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u> <u>VAH, Fort Howard, Md.</u> <u>4/10/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>Charles R. Law Mortuary 802-04 Madison Ave., Balt., Md.</u>				24a. REC'D BY REGISTRAR <u>Apr 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Nathan D. Foster</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3676

CERTIFICATE OF DEATH

0362431
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville		d. STREET ADDRESS 2206 Pine Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2206 Pine Ave.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ReEtta E. Middle Amoss Last		4. DATE OF DEATH Month April Day 4, Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1909
9. AGE (In years last birthday) yrs. 47		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter F. Buppert		14. MOTHER'S MAIDEN NAME Anna M. Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-20-1467	
17. INFORMANT Ralph E. Amoss		Address 2206 Pine Ave. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Congestive Heart Failure, c DUE TO (c) Chronic nephritic disease		INTERVAL BETWEEN ONSET AND DEATH 1 day - 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL - , 19 56 , to APRIL 4, 1956 , that I last saw the deceased alive on APRIL 4 , 19 56 , and that death occurred at 6:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler		ADDRESS (Street, city or town, state) 3601 Cyman Rd - Balt - 4/5/56	
DATE SIGNED 4/5/56			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Howard Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd	
24a. REC'D BY REGISTRAR 9		24b. REGISTRAR'S SIGNATURE Dr. J. W. Martin	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
46. SIGNATURE OF DECEASED [Illegible]		47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF DECEASED [Illegible]		51. SIGNATURE OF DECEASED [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF DECEASED [Illegible]		63. SIGNATURE OF DECEASED [Illegible]	
64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF DECEASED [Illegible]		87. SIGNATURE OF DECEASED [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

BUREAU V. S.

APR 9 1956

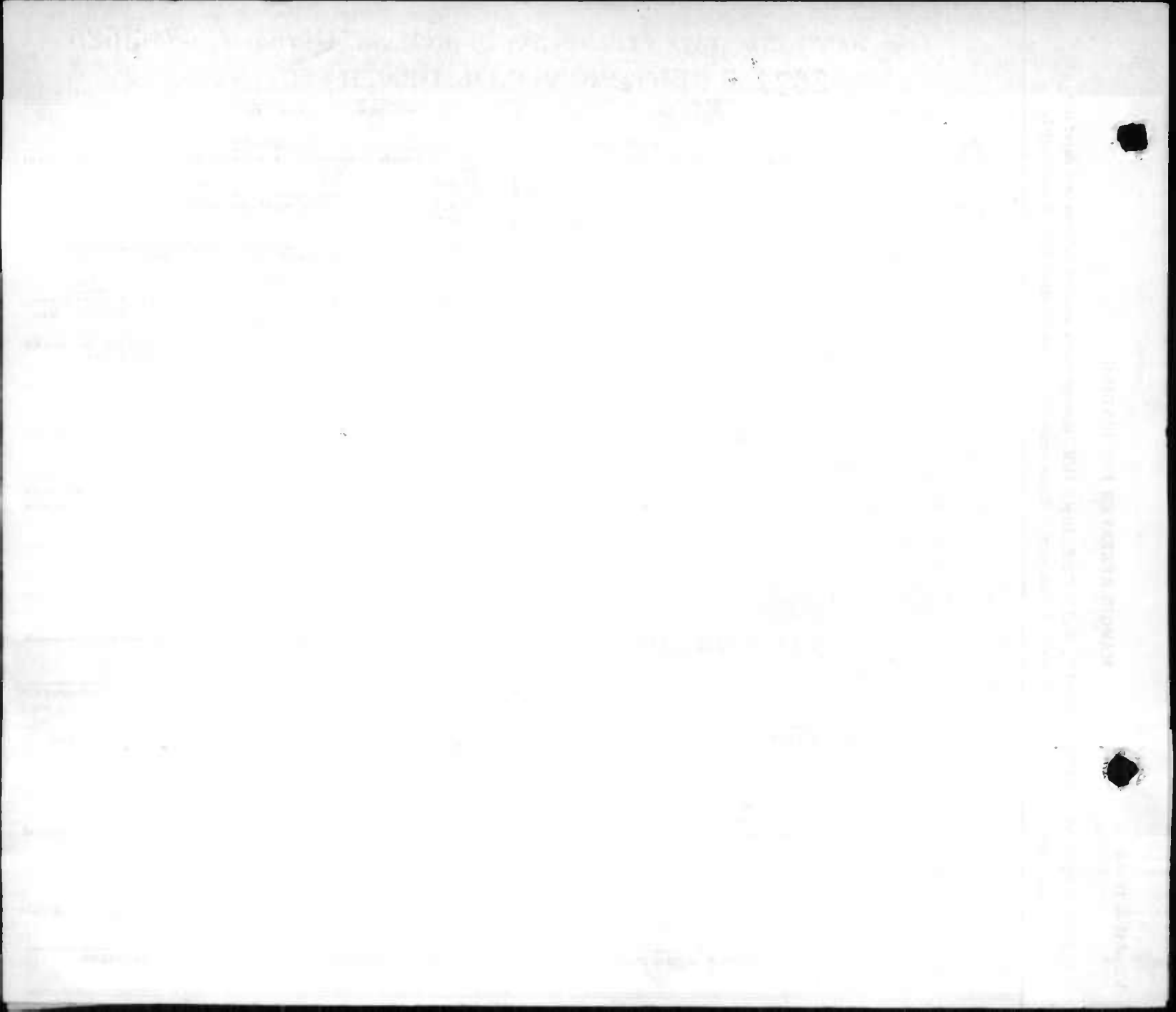
RECEIVED

3677 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) Goldie Josephine Anderson			2. DATE OF DEATH April 26, 1956		
3. PLACE OF DEATH: A. Baltimore City, Maryland Catonsville Baltimore			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1133 Baker Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1133 Baker Avenue		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 25, 1882	9. AGE (In years last birthday) 73	10. Under 1 Year Months: Days 9 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10B. KIND OF BUSINESS OR INDUSTRY Home		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George T. Schaeffer			14. MOTHER'S MAIDEN NAME Sarah E. Hughes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO. none		
17. INFORMANT Samuel D. Anderson			ADDRESS 1133 Baker Ave.		
18. 151X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the stomach CAUSE OF DEATH (A) Carcinoma of the stomach DUE TO (B) 6 mo DUE TO (C) 6 mo			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 26 April 1956 to 26 April 1956 , that (I) (we) last saw the deceased alive on 26 April 1956 , and that death occurred at 12:20 P. m. , from the causes and on the date stated above.					
23A. SIGNATURE G. mil St. Henning Jr. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS 601 Winans Way M.D.		23C. DATE SIGNED 28 April 56	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/30/56	24C. NAME OF CEMETERY OR CREMATORY Lorraine		24D. LOCATION (City, town, or county) (State) Baltimore County
DATE RECEIVED BY LOCAL REGISTRAR April 30 1956		REGISTRAR'S SIGNATURE H. H. Hedrick		25. FUNERAL DIRECTOR H. H. Hedrick ADDRESS 1913 W. Baltimore	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER.



3678

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uppersco Rural</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OF INSTITUTION</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ABRAM-HUBER-ARMACOST</u>		4. DATE OF DEATH <u>April 12 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24-1882</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trading</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. Mitchell Armacost</u>		14. MOTHER'S MAIDEN NAME <u>Frances M. Wisner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-4690</u>	
17. INFORMANT <u>Howard H. Armacost, Uppersco Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>General Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>10 yrs</u> <u>15 yrs</u>	
PART II—OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1940</u> to <u>April 13 56</u> , that I last saw the deceased alive on <u>April 6 56</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.		DATE SIGNED <u>4-13-56</u>	
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. PORTERFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 15 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>4-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Dine</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3078

1-10-1956

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF BIRTH 12-5-20		5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White		9. HIGHEST GRADE OF SCHOOL High School	
10. DATE OF DEATH 4-4-68		11. PLACE OF DEATH MEMPHIS, TENNESSEE		12. CAUSE OF DEATH FIRE	
13. MANNER OF DEATH Suicide		14. PLACE OF INTERMENT None		15. NAME OF FUNERAL HOME None	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF CORONER None		20. SIGNATURE OF JURY None		21. SIGNATURE OF JUDGE None	
22. SIGNATURE OF CLERK None		23. SIGNATURE OF REGISTRAR None		24. SIGNATURE OF NOTARY None	
25. SIGNATURE OF DECEASED'S NEXT OF KIN None		26. SIGNATURE OF DECEASED'S NEXT OF KIN None		27. SIGNATURE OF DECEASED'S NEXT OF KIN None	
28. SIGNATURE OF DECEASED'S NEXT OF KIN None		29. SIGNATURE OF DECEASED'S NEXT OF KIN None		30. SIGNATURE OF DECEASED'S NEXT OF KIN None	
31. SIGNATURE OF DECEASED'S NEXT OF KIN None		32. SIGNATURE OF DECEASED'S NEXT OF KIN None		33. SIGNATURE OF DECEASED'S NEXT OF KIN None	
34. SIGNATURE OF DECEASED'S NEXT OF KIN None		35. SIGNATURE OF DECEASED'S NEXT OF KIN None		36. SIGNATURE OF DECEASED'S NEXT OF KIN None	
37. SIGNATURE OF DECEASED'S NEXT OF KIN None		38. SIGNATURE OF DECEASED'S NEXT OF KIN None		39. SIGNATURE OF DECEASED'S NEXT OF KIN None	
40. SIGNATURE OF DECEASED'S NEXT OF KIN None		41. SIGNATURE OF DECEASED'S NEXT OF KIN None		42. SIGNATURE OF DECEASED'S NEXT OF KIN None	
43. SIGNATURE OF DECEASED'S NEXT OF KIN None		44. SIGNATURE OF DECEASED'S NEXT OF KIN None		45. SIGNATURE OF DECEASED'S NEXT OF KIN None	
46. SIGNATURE OF DECEASED'S NEXT OF KIN None		47. SIGNATURE OF DECEASED'S NEXT OF KIN None		48. SIGNATURE OF DECEASED'S NEXT OF KIN None	
49. SIGNATURE OF DECEASED'S NEXT OF KIN None		50. SIGNATURE OF DECEASED'S NEXT OF KIN None		51. SIGNATURE OF DECEASED'S NEXT OF KIN None	
52. SIGNATURE OF DECEASED'S NEXT OF KIN None		53. SIGNATURE OF DECEASED'S NEXT OF KIN None		54. SIGNATURE OF DECEASED'S NEXT OF KIN None	
55. SIGNATURE OF DECEASED'S NEXT OF KIN None		56. SIGNATURE OF DECEASED'S NEXT OF KIN None		57. SIGNATURE OF DECEASED'S NEXT OF KIN None	
58. SIGNATURE OF DECEASED'S NEXT OF KIN None		59. SIGNATURE OF DECEASED'S NEXT OF KIN None		60. SIGNATURE OF DECEASED'S NEXT OF KIN None	
61. SIGNATURE OF DECEASED'S NEXT OF KIN None		62. SIGNATURE OF DECEASED'S NEXT OF KIN None		63. SIGNATURE OF DECEASED'S NEXT OF KIN None	
64. SIGNATURE OF DECEASED'S NEXT OF KIN None		65. SIGNATURE OF DECEASED'S NEXT OF KIN None		66. SIGNATURE OF DECEASED'S NEXT OF KIN None	
67. SIGNATURE OF DECEASED'S NEXT OF KIN None		68. SIGNATURE OF DECEASED'S NEXT OF KIN None		69. SIGNATURE OF DECEASED'S NEXT OF KIN None	
70. SIGNATURE OF DECEASED'S NEXT OF KIN None		71. SIGNATURE OF DECEASED'S NEXT OF KIN None		72. SIGNATURE OF DECEASED'S NEXT OF KIN None	
73. SIGNATURE OF DECEASED'S NEXT OF KIN None		74. SIGNATURE OF DECEASED'S NEXT OF KIN None		75. SIGNATURE OF DECEASED'S NEXT OF KIN None	
76. SIGNATURE OF DECEASED'S NEXT OF KIN None		77. SIGNATURE OF DECEASED'S NEXT OF KIN None		78. SIGNATURE OF DECEASED'S NEXT OF KIN None	
79. SIGNATURE OF DECEASED'S NEXT OF KIN None		80. SIGNATURE OF DECEASED'S NEXT OF KIN None		81. SIGNATURE OF DECEASED'S NEXT OF KIN None	
82. SIGNATURE OF DECEASED'S NEXT OF KIN None		83. SIGNATURE OF DECEASED'S NEXT OF KIN None		84. SIGNATURE OF DECEASED'S NEXT OF KIN None	
85. SIGNATURE OF DECEASED'S NEXT OF KIN None		86. SIGNATURE OF DECEASED'S NEXT OF KIN None		87. SIGNATURE OF DECEASED'S NEXT OF KIN None	
88. SIGNATURE OF DECEASED'S NEXT OF KIN None		89. SIGNATURE OF DECEASED'S NEXT OF KIN None		90. SIGNATURE OF DECEASED'S NEXT OF KIN None	
91. SIGNATURE OF DECEASED'S NEXT OF KIN None		92. SIGNATURE OF DECEASED'S NEXT OF KIN None		93. SIGNATURE OF DECEASED'S NEXT OF KIN None	
94. SIGNATURE OF DECEASED'S NEXT OF KIN None		95. SIGNATURE OF DECEASED'S NEXT OF KIN None		96. SIGNATURE OF DECEASED'S NEXT OF KIN None	
97. SIGNATURE OF DECEASED'S NEXT OF KIN None		98. SIGNATURE OF DECEASED'S NEXT OF KIN None		99. SIGNATURE OF DECEASED'S NEXT OF KIN None	
100. SIGNATURE OF DECEASED'S NEXT OF KIN None		101. SIGNATURE OF DECEASED'S NEXT OF KIN None		102. SIGNATURE OF DECEASED'S NEXT OF KIN None	

BUREAU V. 3

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be retained by the funeral director for 48 hours after death. Pages 1 and 2 should be filled with
information for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15
15M 9/56

FREDERICK AND WADE AVENUES
CATONSVILLE 28, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3679

CERTIFICATE OF DEATH

03627

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wayne Conv. Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STELLA ARMOUR</u>		4. DATE OF DEATH <u>April 29 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1, 1883</u>
9. AGE (In years, last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr Grace Fairall, Odenton</u>	
17. INFORMANT <u>Mr Grace Fairall, Odenton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cachexia</u> DUE TO <u>Chronic Colitis.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ruptured Appendix Feb 1956</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1954</u> , to <u>29 April 1956</u> , that I last saw the deceased alive on <u>28 April 1956</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W E Mc Grath M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>1707 Edmondson Ave Catonsville 28 MD</u>	
DATE SIGNED <u>5/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried May 1, 56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W E Mc Grath</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

83087

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

NAME OF DECEASED <i>STELLA ARMOUR</i>		DATE OF DEATH <i>April 20 1956</i>	
AGE <i>21</i>		SEX <i>Female</i>	
RACE <i>White</i>		MARRIAGE <i>Never</i>	
BIRTHPLACE <i>St. Louis, Mo.</i>		RESIDENCE <i>St. Louis, Mo.</i>	
OCCUPATION <i>Student</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF DEATH REGISTRAR <i>[Signature]</i>	
DATE OF SIGNATURE <i>April 20 1956</i>		DATE OF SIGNATURE <i>April 20 1956</i>	

BUREAU V. R.

MAY 7 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03628

3680

CERTIFICATE OF DEATH

Item#9, Film G196, 4/30/56 mb

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore CITY OR TOWN Rural - Towson HOSPITAL OR INSTITUTION OR STREET ADDRESS 812 Regester Ave. Balto. 12, Md.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore CITY OR TOWN Baltimore STREET ADDRESS Shirley Hotel 205 W. Madison St., Balto. 1, Md.			
3. NAME OF DECEASED (Type or Print) Virginia Bacon Armstrong				4. DATE OF DEATH (Month) Apr. (Day) 23, (Year) 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 13, 1861	9. AGE last birthday 95 94 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Monkton, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Wm. M. Bacon				14. MOTHER'S MAIDEN NAME Martha Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Alva N. Martin Greenway Apts. Balto. 18, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Coronary Thrombosis						INTERVAL BETWEEN ONSET AND DEATH Immediate	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis						20 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 17, 1956 , to Apr. 23, 1956 , that I last saw the deceased alive on Apr. 17, 1956 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.							
SIGNATURE William F. Pearce		M.D. 2105 N. Charles St. Baltimore 18 Md.		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-26-1956		NAME OF CEMETERY OR CREMATORY St. James Cemetery		LOCATION (City, town, or county) (State) My Lady's Manor, Md.	
24. REC'D BY REGISTRAR 25 1956		REGISTRAR'S SIGNATURE Malcolm Gray		25. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc. ADDRESS 4905 York Rd., Balto. 12, Md.			

CERTIFICATE OF DEATH

REG. 2011-100

1. NAME OF DECEASED (Print or Write)

JOHN W. JONES

2. SEX

Male

3. AGE

45

4. DATE OF DEATH

April 23, 1956

5. TIME

10:30 AM

6. PLACE

Home

7. CAUSE

Heart Disease

8. MANNER

Natural

9. SIGNATURE

Dr. J. H. Smith

BUREAU V. S.

APR 25 1956

RECEIVED

EXHIBIT

This is a true and correct copy of the original as filed in the files of the Department of Health, State of Maryland, and is certified to be so by the undersigned, Registrar of the Department of Health, State of Maryland, on this 25th day of April, 1956.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03629

3681

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria & Guernsey Rd</u>		STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Magdalen Baierl</u>	(First) _____ (Middle) _____ (Last) _____	4. DATE OF DEATH <u>April 15 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 22, 1881</u>
9. AGE last birthday <u>74</u> yrs.		10. If under 1 year Months _____ Days _____ If under 24 hrs. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Rochester N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Baierl</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Kohlmaier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY No. _____	
(If yes, give war or dates of service) _____		17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md.</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Intestinal obstruction</u>	<u>8 days</u>
Antecedent cause(s) (b) <u>Carcinoma of ascending colon</u>	<u>6 yrs.</u>
(c) _____	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	(STATE) _____
21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	PLACE (Home, farm, factory, street, OF office bldg., etc.) _____ (CITY OR TOWN) _____ (COUNTY) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from May....., 1952., to April 15....., 1956., that I last saw the deceased alive on Dec. 13....., 1955., and that death occurred at 1:45.....P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

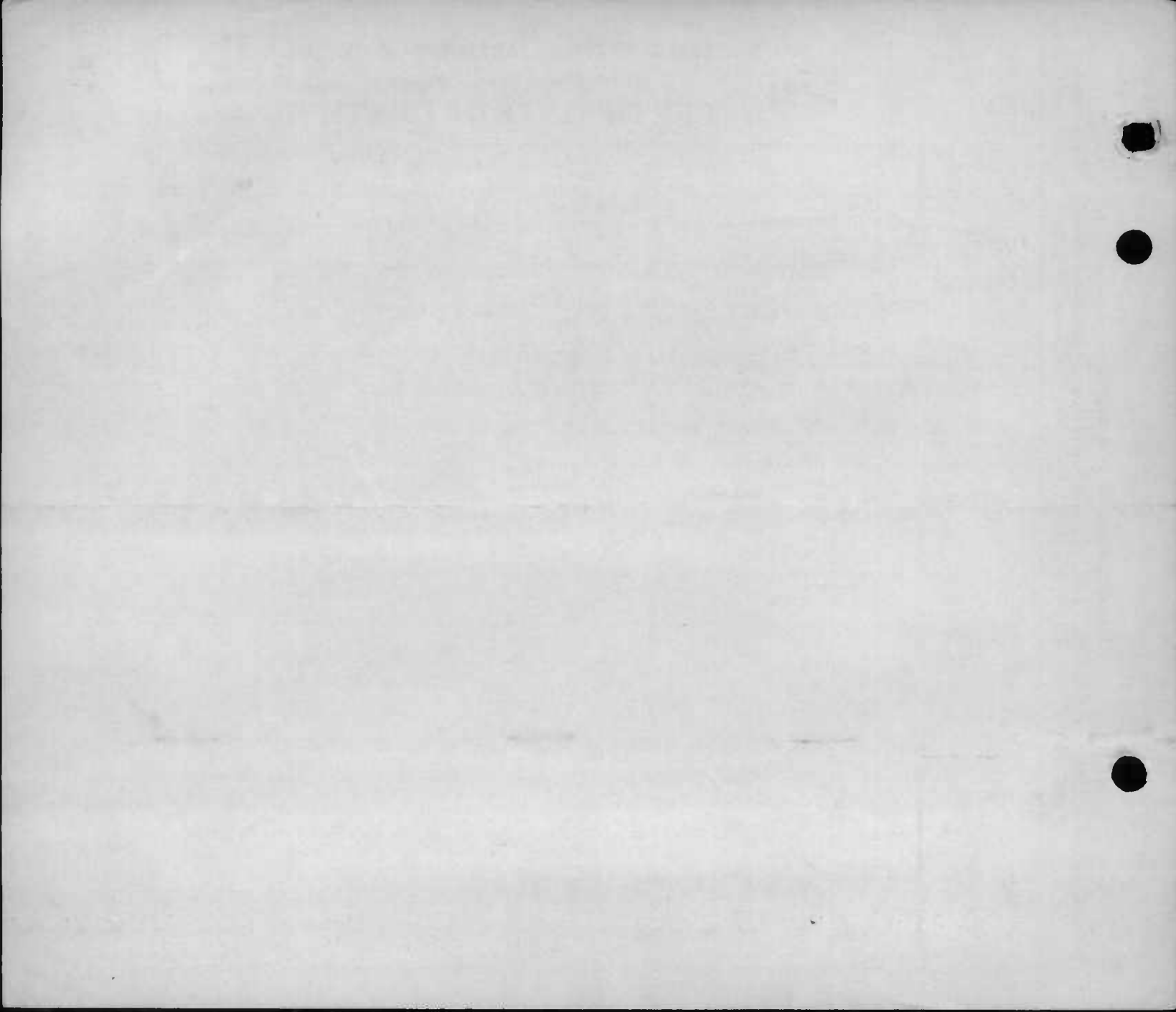
ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-17-56</u>	NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>	LOCATION (City, town, or county) <u>NOTCH CLIFF NEAR TOWSON, MD.</u>	(State) _____
DATE REC'D BY LOCAL REG. <u>4/16/56</u>	REGISTRAR'S SIGNATURE <u>Chas. J. Donnell</u>	24. FUNERAL DIRECTOR <u>Charles J. Baierl</u>	ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803630

3682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

Helen E. Baker

2. DATE
OF
DEATH

April 7, 1956

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore County

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

55 217 Dunkirk Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

217 Dunkirk Road

c. Length of stay in Baltimore

00

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Aug. 10, 1882

9. AGE (In years last birthday)

73

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles F. Hamilton

14. MOTHER'S MAIDEN NAME

Emma Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO. 220-01-2683A

17. INFORMANT

Miss Helen Hamilton, 107-50-109th St.

ADDRESS

18.

422-1

CAUSE OF DEATH

Richmond Interval Between Onset and Death

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

QUE TO

Arteriosclerosis
L. V. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

Yes ☐ NO ☐

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Apr. 7, 1956 to Apr. 7, 1956, and that death occurred at 11:00 Am., from the causes and on the date stated above.

23A. SIGNATURE

Attending Phys. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

23B. ADDRESS

7101 Harford Rd.

23C. DATE SIGNED

4/7/56

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/10/56

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county) (State)

Edmondson Ave, Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm Cook - Blight Inc

25. FUNERAL DIRECTOR

ADDRESS

Wm Cook - Blight Inc 6009 HARFORD RD

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. The Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

b. COUNTY **Baltimore**

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Day	Year
16	1981

IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Months	Days	Hours	Min.

U.S.A.

Emma McElroy

Oella, Md.

INTERVAL BETWEEN
ONSET AND DEATH

19. WAS AUTOPS PERFORMED?
YES ☐ NO ☒

(State)

DATE _____ SIGN _____

DATE SIGNED
4/17/56

(State)

24b. REGISTRAR'S SIGNATURE

VE. Harris

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

3288

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		Boston, Mass.		Boston, Mass.		Heart Disease		Natural		Teacher		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Report		Place of Report	
Jan 15, 1956		10:30 AM		Home		Boston, Mass.		Heart Disease		Natural		Teacher		[Signature]		[Signature]		Jan 16, 1956		Boston, Mass.	

BUREAU V. 51

JAN 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3666

CERTIFICATE OF DEATH

03632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethrope		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethrope	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1818 Winanns Ave		d. STREET ADDRESS 1818 Winanns Ave	
3. NAME OF DECEASED (Type or print) Thelma May Barry		4. DATE OF DEATH April 15, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 26, 1900
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Augustus W. Bryan	
14. MOTHER'S MAIDEN NAME Mary R. Green		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT John N. Barry, 1818 Winanns Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato Renal Syndrome 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary to Carcinomatosis DUE TO (c) Primary Lesion - CH Rectum		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/4 , 19 50 , to 1/15 , 19 56 , that I last saw the deceased alive on 1/14 , 19 56 , and that death occurred at 505 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Realy M.D.		DATE SIGNED April 15, 1956	
PHYSICIAN'S NAME (Type) John C. Realy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 18, 1956	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR APR 18 1956 24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Luff	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 18 1956

RECEIVED
APR 18 1956

3684

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Miss Odd's Nursing Home 301 W. Chesapeake Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Henckel Barth				4. DATE OF DEATH Month April Day 23 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1877	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Mt. Savage Maryland		11. BIRTHPLACE (State or foreign country) U. S.	
13. FATHER'S NAME John Henckel				14. MOTHER'S MAIDEN NAME Ellem Findlay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Margaret E. Uhl.				Address Mt. Savage Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic C-V disease DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 3/7 , 19 55 , to 4/25 , 19 56 , that I last saw the deceased alive on 3/25 , 19 56 , and that death occurred at 3:50 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Tos. A. Seelack				M.D. 200 W. Penna. Ave 4/25/56			
PHYSICIAN'S NAME (Type) Tos. A. Seelack				Towson 4, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/1956		22c. NAME OF CEMETERY OR CREMATORY St. Georges Church Cem		22d. LOCATION (City, town, or county) (State) Mt. Savage Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins and Sons Co., Inc.				ADDRESS 4905 York Road. Balto., 12. Md.		24a. REC'D BY REGISTRAR APR 25 1956	
				24b. REGISTRAR'S SIGNATURE Nichol Gray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. R.

APR 26 1956

RECEIVED

3685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>				c. LENGTH OF STAY IN 1b <u>137 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. STREET ADDRESS <u>2107 Elsinor Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>WILBUR</u> Middle <u>C.</u> Last <u>BARTON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/97</u>		9. AGE (In years last birthday) <u>59</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Monkton, Maryland</u>	
13. FATHER'S NAME <u>Charles Barton</u>				14. MOTHER'S MAIDEN NAME <u>Anna Durmont</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA WITH METASTASIS</u> <u>162x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>7 Months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <u>VA</u> attended the deceased from <u>November 30, 1955</u> , to <u>April 15, 1956</u> , that I last saw the deceased alive on <u>April 12, 1956</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold S. Tidler</u> M.D.				ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>4/15/56</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD S. TIDLER, M. D.</u>				ADDRESS <u>VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>4/15/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4.19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hereford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tidler & Sons, Inc.</u> <u>Wm. J. Tidler & Sons, Inc., North & E. Ays.</u> <u>Baltimore, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lewison L. Farber</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 18 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03635

CERTIFICATE OF DEATH

Reg. Dist. No. 41

3651

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK 22</u>	LENGTH OF STAY (in this place) <u>14 YRS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7013 DUNBAR Rd</u>		STREET ADDRESS (If rural give location) <u>7013 DUNBAR Rd</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>MINNIE</u> (Middle) <u>SAUNDERS</u> (Last) <u>BASKIETTE</u>		(Month) <u>4</u> (Day) <u>19</u> (Year) <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV 6, 1874</u>
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>VA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>SAUNDERS</u>		14. MOTHER'S MAIDEN NAME <u>JNK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>MRS. SCOTT N. STINER — SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
170X IMMEDIATE CAUSE (A) <u>Carcinoma Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Primary Breast Cancer</u>			<u>2 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 55</u> , 19 <u>55</u> , to <u>April 56</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>18 Apr 56</u> ; and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Wm. Kelly</u>		ADDRESS (Street, city, town, state) <u>3 Kinship Rd Balto 22</u>	
DATE <u>APR 25 1956</u>		DATE SIGNED <u>20 Apr 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>4-21-56</u>	NAME OF CEMETERY OR CREMATORY <u>OLAK LAWN</u>	LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Kelly</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

3686

CERTIFICATE OF DEATH

03636

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 373 NICHOLSON ROAD.				d. STREET ADDRESS 373 Nicholson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Benhoff Last Benhoff				4. DATE OF DEATH Month April Day 27th Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10th, 1893		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 3 Days 17	IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Cooksey				14. MOTHER'S MAIDEN NAME Fannie Kromling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Edward Benhoff (Husband) Above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hr 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 11, 1951 to April 27, 1956 , that I last saw the deceased alive on April 27, 1956 , and that death occurred at 4:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Niceli M.D.				ADDRESS (Street, city or town, state) Essex DATE SIGNED 4/30/56			
PHYSICIAN'S NAME (Type) JOSEPH NICELI, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		April 30th, 56		Oak Lawn		Eastern Blvd., Balto Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. G. Connolly				ADDRESS 418 Eastern Blvd.		24a. REC'D BY REGISTRAR DATE MAY 1 1956	
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4335

BUREAU V. S.

MAY 1 1956

RECEIVED

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3687 CERTIFICATE OF DEATH

03637

38

Item 2, Film G197 5-11-56 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR end give nearest town) Parkville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) Parkville		COUNTY Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Oak Haven Nursing Home				STREET ADDRESS 3422 Joppa Road		(If rural give location) Nursing Home	
3. NAME OF DECEASED (Type or Print) FANNIE KLINE BICKFORD				4. DATE OF DEATH (Month) April , (Day) 21 , (Year) 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH November 24, 1877	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Kline				14. MOTHER'S MAIDEN NAME Amanda Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Walter Carswell, Timonium, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) arteriosclerotic CVD						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/1/56, 19, to 4/21/56, 19, that I last saw the deceased alive on 4/20/56, 19, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE Harold A. Gatt		M.D. 8100 Harford Rd.		DATE SIGNED 4/23/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 24, 1956		NAME OF CEMETERY OR CREMATORY Sherwood Episcopal Cem.		LOCATION (City, town, or county) (State) Cockeysville, Maryland	
24. REC'D BY REGISTRAR DATE 4/23/56		REGISTRAR'S SIGNATURE P. M. Bacon		25. FUNERAL DIRECTOR'S SIGNATURE John Burns, Son		ADDRESS Towson, Md.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

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BUREAU V. S.

MAY 2 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3688

CERTIFICATE OF DEATH

03638

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN Mt. Wilson				TOWN BALTIMORE		3701-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital				STREET ADDRESS 911 St Paul Street (If rural give location) ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WILLIAM (Middle) G (Last) BLOSS				(Month) April (Day) 16 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	6-17-1904	51 yrs.	Months 10 Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SAILOR				BALTIMORE		U.S.A.	
13. FATHER'S NAME WILLIAM BLOSS				14. MOTHER'S MAIDEN NAME ALICE SEYMOUR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
UNK.		unk.		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) TUBERCULOUS MENINGITIS				INTERVAL BETWEEN ONSET AND DEATH 6 days			
ANTECEDENT CAUSE(S) DUE TO (B) PULMONARY TUBERCULOSIS				40 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-5-1956 , to 4-16-1956 , that I last saw the deceased alive on 4-15-1956 , and that death occurred at 10:25 AM , from the causes and on the date stated above.							
SIGNATURE William Newman				DATE SIGNED			
M.D. Mt. Wilson, Maryland				ADDRESS (Street, city, town, or county)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4/19/56		Mt. Carmel Cemetery		Baltimore, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE APR 19 1956		Mrs. Dorothy Newell		Wm Cook Inc. 1217 St. Paul St			

CERTIFICATE OF DEATH

See, Out, 110

A. NAME, ADDRESS, AND DATE OF OCCURRENCE

NAME
ADDRESS
CITY
STATE
COUNTY
DATE

LOCALITY
COUNTY
STATE
CITY
ADDRESS
DATE

DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH
MANNER OF DEATH
DISEASE
SYMPTOMS
TREATMENT
PREVIOUS ILLNESS

EDUCATION
OCCUPATION
RELIGION
MARRIAGE

DATE OF BIRTH
PLACE OF BIRTH
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BUREAU V. S.

APR 10 1933

RECEIVED

3689

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Randallstown</u>				TOWN <u>Randallstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Offutt Road</u>				STREET ADDRESS (If rural give location) <u>Offutt Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Anna S. Blottenberger</u>				<u>Apr. 7 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Dec. 4, 1874</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At home</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore Co., Md.</u>	
13. FATHER'S NAME: <u>John Popp</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Walter A. Proctor - Offutt Rd.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19..... , to , 19..... , that I last saw the deceased alive on 4/18, 1956, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE <u>Lorraine Blottenberger</u> M.D.				ADDRESS DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/11/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-11-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR'S ADDRESS <u>4600 Liberty Hgts. Ave.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WASH DC
JAN 10 1964
COMM-FED
AVALIA

03640

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 415 N. Pine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle G. Last BOOKER		4. DATE OF DEATH Month April Day 14 Year 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/99	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Henry Booker		14. MOTHER'S MAIDEN NAME Nannie Barrett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. 213-20-2214		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIC CONVULSION 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RENAL INSUFFICIENCY DUE TO (c) KIMMELSTIEL'S WILSON'S DISEASE		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours 10 years 12 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arbutus, Maryland	
20f. (City or town) Arbutus		(County) Arbutus		(State) Maryland	
21. I certify that I attended the deceased from March 28, 1956 , to April 14, 1956 , that I saw the deceased alive on April 14, 1956 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland		DATE SIGNED 4/15/56	
ACTUAL SIGNATURE Harold S. Tidler		M.D. VAH, Fort Howard, Maryland			
PHYSICIAN'S NAME (Type) HAROLD S. TIDLER, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-56		22c. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery	
22d. LOCATION (City, town, or county) Arbutus, Maryland		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Paymer Sanders Funeral Home 217 E. Preston St., Baltimore, Md.		ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR 4/18/56	
24b. REGISTRAR'S SIGNATURE Lawson L. Fisher					

VS A15 (4)
15M 9/SS

CERTIFICATE OF DEATH

5280

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH FBI Headquarters, Washington, D.C.	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Memphis, Tennessee	
10. OCCUPATION Attorney		11. EDUCATION High School		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. SOCIAL SECURITY NUMBER [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]	
16. SIGNATURE OF WITNESS [REDACTED]		17. SIGNATURE OF PHYSICIAN [REDACTED]		18. SIGNATURE OF CORONER [REDACTED]	
19. SIGNATURE OF JUDGE [REDACTED]		20. SIGNATURE OF CLERK [REDACTED]		21. SIGNATURE OF [REDACTED]	
22. SIGNATURE OF [REDACTED]		23. SIGNATURE OF [REDACTED]		24. SIGNATURE OF [REDACTED]	
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100. SIGNATURE OF [REDACTED]		101. SIGNATURE OF [REDACTED]		102. SIGNATURE OF [REDACTED]	

RECEIVED
APR 19 1968
BUREAU V. S.

03641

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3691

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Immediately</u> LENGTH OF STAY (in this place) <u>11 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Immediately North of Balto. City Line</u>	
TOWN <u>North of Balto. City Line</u>		TOWN <u>Immediately North of Balto. City Line</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5908 Liberty Road</u>		STREET ADDRESS (If rural, give location) <u>5908 Liberty Road</u> 7	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>Wallace</u> (Last) <u>Boone</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Nov. 6, 1885</u>
9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John W. Boone</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rosa Bowersox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>James K. Hughlett</u> 5908 Liberty Road 7	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Hypertensive Cardiovascular Disease</u>		
Antecedent cause(s) (b) <u>Extensive Generalized Angina Pectoris</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary Artery</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1953, to April 27, 1956; that I last saw the deceased alive on April 26, 1956; and that death occurred at 3:15 P.M. m., from the causes and on the date stated above.

SIGNATURE <u>William D. Jurewicz M.D.</u>	ADDRESS <u>2711 Eastern Ave.</u>	DATE SIGNED <u>4/27/56</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 1, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>
LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State) <u>Maryland</u>	
DATE REC'D BY LOCAL REG. <u>April 30, 1956</u>	REGISTRAR'S SIGNATURE <u>C. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>
ADDRESS <u>3631 Falls Road</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Melvin J. Jaworski
2711 Eastern Ave.
Pe. 2-3591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3692

CERTIFICATE OF DEATH

03642

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 2yrs. 6mos. 27days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Hurst Last Brent				4. DATE OF DEATH Month April Day 11 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-1874	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Captain				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas Brent			
14. MOTHER'S MAIDEN NAME Susan Hurst				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Records Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9-15- 19 53 , to 4-11- 19 56 , that I last saw the deceased alive on 4-10- 19 56 , and that death occurred at 2:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4-11-56 ACTUAL SIGNATURE Stella Wachslar M.D. Spring Grove State Hospital PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Old Morratice Baptist		22d. LOCATION (City, town, or county) (State) Kilmarnock, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR DATE 4/11/56		24b. REGISTRAR'S SIGNATURE V. E. Sherry	

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		TIME OF BIRTH [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF INTERMENT [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]	

RECEIVED
 APR 13 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3693 CERTIFICATE OF DEATH

03643

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-VILLANOVA		c. LENGTH OF STAY IN 1b 6 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ESSEX RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth		4. DATE OF DEATH April 4 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 25, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS, OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Pedberg		14. MOTHER'S MAIDEN NAME Bessie Sewald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Edwin L. Pierpont, M.D.		Address 8204 Liberty Rd, Balto 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Vascular 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Embolism of Vessels DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1953 , to April 4, 1956 , that I last saw the deceased alive on April 4, 1956 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin L. Pierpont		DATE SIGNED April 7, 1956	
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.		ADDRESS (Street, city or town, state) 8204 LIBERTY RD. BALTO. 7, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried April 7, 1956		22b. DATE THEREOF April 7, 1956	
22c. NAME OF CEMETERY OR CREMATORY Edenwald Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		ADDRESS 1115 E. Hillerich	
24a. REC'D BY REGISTRAR Dr. J. M. Mathis		24b. REGISTRAR'S SIGNATURE Dr. J. M. Mathis	

CERTIFICATE OF DEATH

3693

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE 18

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]		11. SIGNATURE OF CLERK [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]		15. SIGNATURE OF SURVIVOR [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF NEXT OF KIN [Faint text]		18. SIGNATURE OF SURVIVOR [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF NEXT OF KIN [Faint text]		21. SIGNATURE OF SURVIVOR [Faint text]	
22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF NEXT OF KIN [Faint text]		24. SIGNATURE OF SURVIVOR [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF NEXT OF KIN [Faint text]		27. SIGNATURE OF SURVIVOR [Faint text]	
28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF NEXT OF KIN [Faint text]		30. SIGNATURE OF SURVIVOR [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF NEXT OF KIN [Faint text]		33. SIGNATURE OF SURVIVOR [Faint text]	
34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF NEXT OF KIN [Faint text]		36. SIGNATURE OF SURVIVOR [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF NEXT OF KIN [Faint text]		39. SIGNATURE OF SURVIVOR [Faint text]	
40. SIGNATURE OF DECEASED [Faint text]		41. SIGNATURE OF NEXT OF KIN [Faint text]		42. SIGNATURE OF SURVIVOR [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF NEXT OF KIN [Faint text]		45. SIGNATURE OF SURVIVOR [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF NEXT OF KIN [Faint text]		48. SIGNATURE OF SURVIVOR [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF NEXT OF KIN [Faint text]		51. SIGNATURE OF SURVIVOR [Faint text]	
52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF NEXT OF KIN [Faint text]		54. SIGNATURE OF SURVIVOR [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF NEXT OF KIN [Faint text]		57. SIGNATURE OF SURVIVOR [Faint text]	
58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF NEXT OF KIN [Faint text]		60. SIGNATURE OF SURVIVOR [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF NEXT OF KIN [Faint text]		63. SIGNATURE OF SURVIVOR [Faint text]	
64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF NEXT OF KIN [Faint text]		66. SIGNATURE OF SURVIVOR [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF NEXT OF KIN [Faint text]		69. SIGNATURE OF SURVIVOR [Faint text]	
70. SIGNATURE OF DECEASED [Faint text]		71. SIGNATURE OF NEXT OF KIN [Faint text]		72. SIGNATURE OF SURVIVOR [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF NEXT OF KIN [Faint text]		75. SIGNATURE OF SURVIVOR [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF NEXT OF KIN [Faint text]		78. SIGNATURE OF SURVIVOR [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF NEXT OF KIN [Faint text]		81. SIGNATURE OF SURVIVOR [Faint text]	
82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF NEXT OF KIN [Faint text]		84. SIGNATURE OF SURVIVOR [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF NEXT OF KIN [Faint text]		87. SIGNATURE OF SURVIVOR [Faint text]	
88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF NEXT OF KIN [Faint text]		90. SIGNATURE OF SURVIVOR [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF NEXT OF KIN [Faint text]		93. SIGNATURE OF SURVIVOR [Faint text]	
94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF NEXT OF KIN [Faint text]		96. SIGNATURE OF SURVIVOR [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF NEXT OF KIN [Faint text]		99. SIGNATURE OF SURVIVOR [Faint text]	
100. SIGNATURE OF DECEASED [Faint text]		101. SIGNATURE OF NEXT OF KIN [Faint text]		102. SIGNATURE OF SURVIVOR [Faint text]	

BUREAU V. 3

APR 10 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE 18

3694

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sherwood Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Dance Brooks				4. DATE OF DEATH Month Day Year 4-15-56 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-1862		9. AGE (In years last birthday) yrs. 95	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY National Bank		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel B. Brooks				14. MOTHER'S MAIDEN NAME Sarah Ensor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-14-9873		17. INFORMANT Address G. Milton Brooks, Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x Congestive Heart Disease DUE TO (b) Parkinson's Disease DUE TO (c) Arteriosclerosis, General. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 22 days 5 yrs unk	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/12 , 19 56 , to 4/15 , 19 56 , that I last saw the deceased alive on 4/15 , 19 56 , and that death occurred at 8:35 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Bennett A. Stoen M.D.				ADDRESS (Street, city or town, state) Lutherville DATE SIGNED 4/16/56			
PHYSICIAN'S NAME (Type) Bennett A. Stoen				Lutherville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-56		22c. NAME OF CEMETERY OR CREMATORY Black Rock Baptist		22d. LOCATION (City, town, or county) (State) Butler, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks				ADDRESS Sparks, Md.		24a. REC'D BY REGISTRAR DATE 18 April 56	
				24b. REGISTRAR'S SIGNATURE Anne Armitstead MacRae			

MEDICAL CERTIFICATION

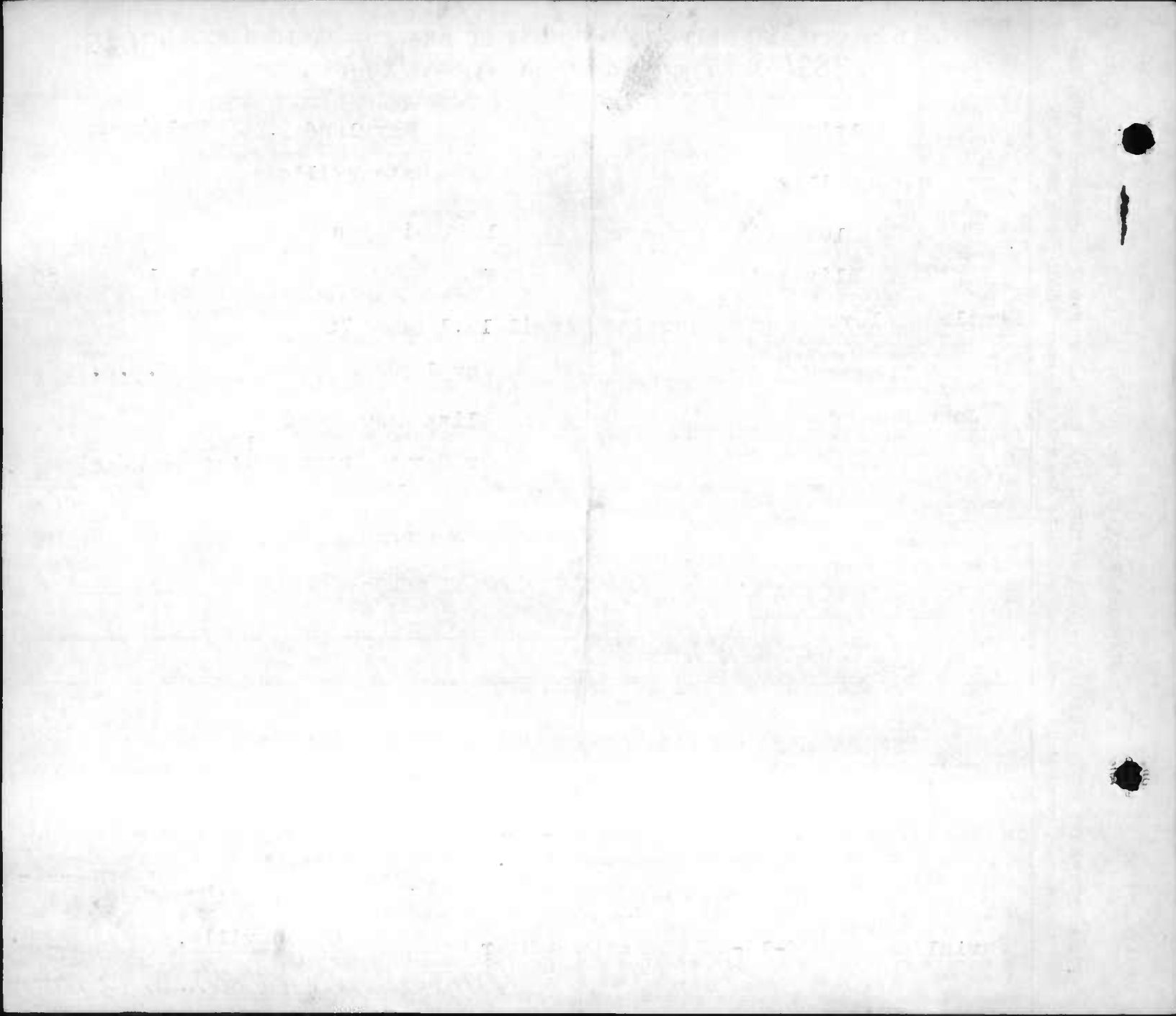
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803645
3695 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 104A Winters Lane	STREET ADDRESS (If rural give location) 104A Winters Lane		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Elizabeth	(Middle)	(Last) Brown	DEATH: April 10 19 56
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: April 12, 1880
9. AGE last birthday 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Howard		14. MOTHER'S MAIDEN NAME: Eliza Anna Bond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Mr Harry Brown 104A Winters Lane			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Cerebral Hemorrhage			22 days
ANTECEDENT CAUSE (S) Hypertensive Arterio-sclerosis			?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-19-56 , 1956, to 4-10-56 , 1956 that I last saw the deceased alive on 4-10-56 , 1956, and that death occurred at 6.30 PM , from the causes and on the date stated above.			
SIGNATURE C. H. Maloney		DATE SIGNED 4-10-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-14-56	
NAME OF CEMETERY OR CREMATORY Western Star Cem		LOCATION (City, town, or county) (State) Catonsville, Md.	
DATE REC'D BY LOCAL REGISTRAR 56		REGISTRAR'S SIGNATURE W. A. Hedrick	
FUNERAL DIRECTOR Mr. Frances A. Hensley		ADDRESS 578 W. Biddle St.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3696

CERTIFICATE OF DEATH

03646
33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cwings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18, Maryland</u>		d. STREET ADDRESS <u>2911 N. Calvert St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julian</u> Middle <u>Hinault</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 56</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/3/1900</u>		9. AGE (In years last birthday) <u>56</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Unascertained</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia Hinault</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Rosewood Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia with hydro and pyro nephrosis with stones,</u> DUE TO (b) <u>multible - bilaterally</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Tuberculosis moderately severe with cavities, bilaterally.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Admitted with T.B. 9/24/51</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericarditis, fibrous, chronic.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 24, 19 51</u> , to <u>April 9, 19 56</u> , that I last saw the deceased alive on <u>April 9, 19 56</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED		ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.		PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>April 12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Cwings Mills Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer, Sons Ruststown</u>	
24a. REC'D BY REGISTRAR <u>4-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>		24c. DATE		24d. REGISTRAR'S SIGNATURE		24e. DATE	

Figure 10.10. (a) α and (b) β rays

BUREAU V. ST.

APR 16 1955

RECEIVED

3652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>53 Dundalk</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk</u> <u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 712 S. 51st</u>		STREET ADDRESS (If rural give location) <u>712 S. 51st st.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Rose L. Browning</u>		OF DEATH: <u>4/8/56</u> 19 <u>56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, <u>Widowed</u> (Specify)	8. DATE OF BIRTH: <u>2/2/89</u>
9. AGE last birthday <u>67</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Md.</u>	11. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
13. FATHER'S NAME: <u>George Holland</u>		14. MOTHER'S MAIDEN NAME: <u>Fannie Thorn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Leone Kesselring 712 S. 51st st.</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>		<u>2 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Coronary infarction</u>		<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Artero-Sclerosis / Hypertension</u>		<u>6 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Aug 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/8</u> , 19 <u>56</u> , and that death occurred at <u>6 a</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Moni G. Javer</u>		DATE SIGNED <u>4/9/56</u>	
M.D. <u>1010 North Point - Rd.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/10/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto.</u>		LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/9/56</u>		REGISTRAR'S SIGNATURE <u>Wm Cook Inc. 1217 St. Paul St.</u>	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
3697 -- CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03648

Reg. Dist. No.

Item 2, Film 495 4-16-56 et

1. PLACE OF DEATH - COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY City <input checked="" type="checkbox"/>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Towson		LENGTH OF STAY (In this place) 1 1/2 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) Towson Baltimore		3601-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Armacost Nursing Home				STREET ADDRESS (If rural, give location) 1908 Park Ave.			
3. NAME OF DECEASED (First) (Middle) (Last) Marie F Buckley		4. DATE OF DEATH (Month) (Day) (Year) April 3 1956					
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Nov. 10, 1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Solomon H. Freburger		14. MOTHER'S MAIDEN NAME Mary Haggerty					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John L. Buckley, Jr. 100 Edgevale Road			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<p>4221 Immediate cause (a) <i>Arteriosclerotic degenerative C.V.D.</i></p> <p>Antecedent cause(s) (b) <i>Chronic Nephritis & uremia.</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Residual of left hemiplegia</i></p>		<p><i>15 years</i></p>	
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
		<p><i>12 hrs.</i></p> <p><i>uterine fibroids with uterine hemorrhage</i></p> <p><i>weeks</i></p>	
20. AUTOPSY?			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

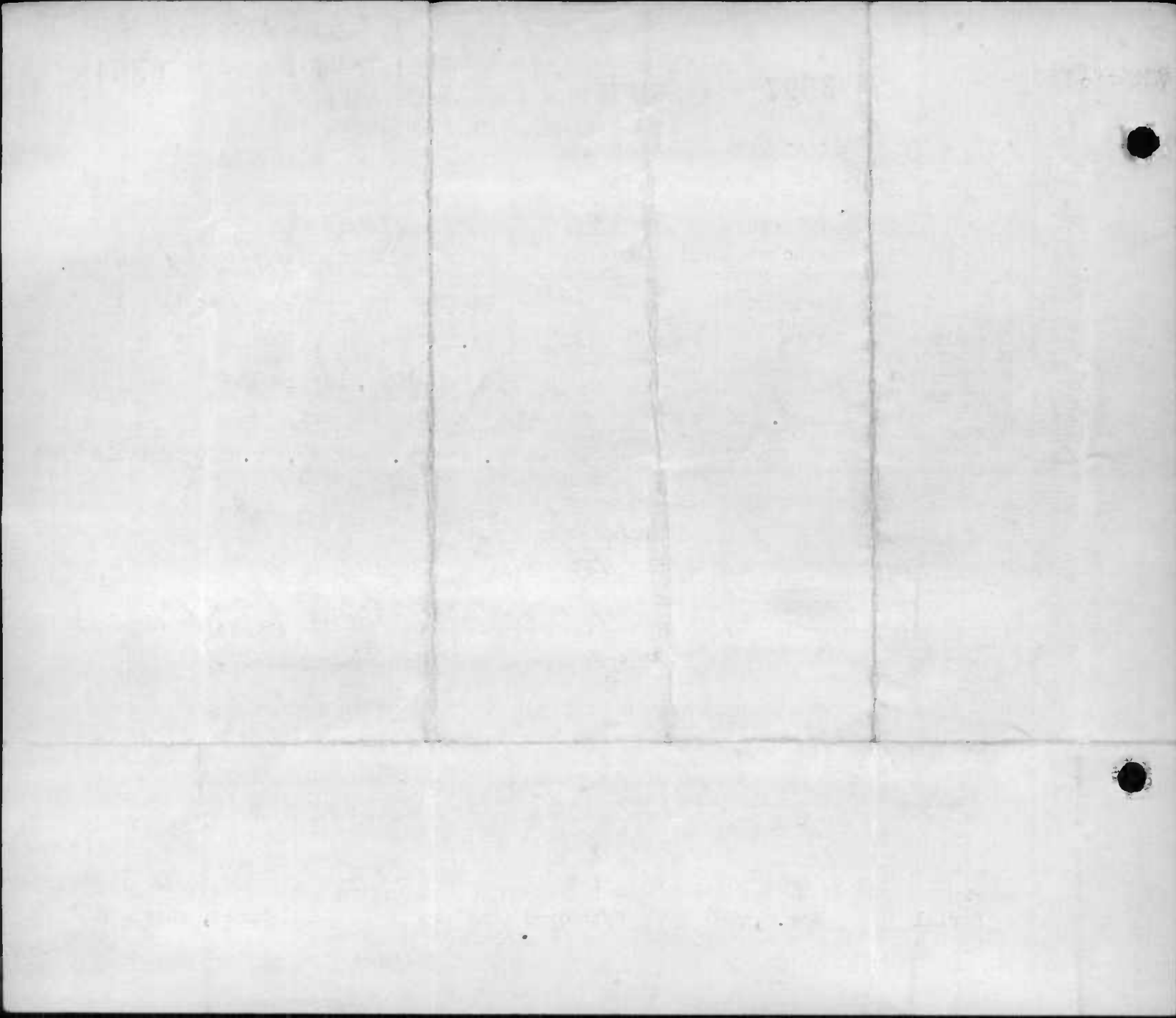
22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Joseph E. Muse Jr. M.D. 5 West 29th St. Balt 18. Md 4 Apr. '56

23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Apr. 6, 1956		NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<i>H. W. Mearns</i>		<i>505 N. Calvert St.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03649

3698

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 28 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 22 N. EAST AVENUE			
3. NAME OF DECEASED (Type or print) EDWARD J. BURKE				4. DATE OF DEATH Month APRIL Day 29 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-96	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER				10b. KIND OF BUSINESS OR INDUSTRY OIL COMPANY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WILLIAM A. BURKE			
14. MOTHER'S MAIDEN NAME ELIZABETH MYER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW-1			
16. SOCIAL SECURITY NO. UNKNOWN				17. INFORMANT CLIN. REC., VET. ADM. HOSP., FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CCR PULMONALE							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from April 1, 1956 , to April 29, 1956 and that death occurred at 8:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED 4/30/56			
PHYSICIAN'S NAME (Type) DONALD D. MARK				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-3-56		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Moran Funeral Home, 3000 E. Baltimore St., Baltimore, Md.				24a. REC'D BY REGISTRAR 5/2/56		24b. REGISTRAR'S SIGNATURE Lawson L. Larkins	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03650

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River Md. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GLENN L. MARTIN DISP PHARM				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore. d. STREET ADDRESS 2537 Robb St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William F. Middle Burke. Last 4. DATE OF DEATH Month April Day 5 Year 1956				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 25, 1910 9. AGE (In years last birthday) 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Glen L. Martin Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Francis M. Burke.				14. MOTHER'S MAIDEN NAME Francis M. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-03-8522		17. INFORMANT Joseph Valenza 2658 Miles Ave. Address			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion DUE TO Chronic Myocarditis & AORTIC STENOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Stenosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5m in - Not known	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. DAVIS M.D.				DATE SIGNED 4/6/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 9, 1956		22c. NAME OF CEMETERY OR CREMATORY Western.		22d. LOCATION (City, town, or county) (State) Edmonson Ave, Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenoweth Jr. ADDRESS 3615-17 Chestnut Ave.				24a. REC'D BY REGISTRAR APR 9 1956		24b. REGISTRAR'S SIGNATURE Mrs. Edith Hurley	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1035
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
1035
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 10 1956

RECEIVED

3700

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b 76 Days		d. STREET ADDRESS 926 N. Calvert Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last CAMPBELL		4. DATE OF DEATH Month April Day 7 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-81
9. AGE (In years lost birthday) yrs. 74		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE CAMPBELL		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES <input checked="" type="checkbox"/> WW-1		16. SOCIAL SECURITY NO. 218-28-1268	
17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from January 22, 1956 , to April 7, 1956 , that I last saw the deceased alive on April 7, 1956 , and that death occurred at 2:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Surmonte		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) JOHN A. SURMONTE		DATE SIGNED 4/7/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 4-9-56	22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEMETERY	22d. LOCATION (City, town, or county) (State) WILMINGTON, DELAWARE
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT INC. FUNERAL HOME, 6009 HARFORD ROAD, BALTIMORE, MD.		24a. REC'D BY REGISTRAR RR 9 1956	
24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0365233

3701

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Upperco</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>10</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>S</u> Middle <u>C</u> Last <u>CAPE</u>				4. DATE OF DEATH <u>April 22</u> Month <u>22</u> Day <u>1956</u> Year			
5. SEX <u>H</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31-1884</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund Starnes</u>				14. MOTHER'S MAIDEN NAME <u>Julia Rouer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>John W Cape - Hampstead Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>Hypertrophic arthritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>hour</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-45</u> to <u>4-22-56</u> , that I last saw the deceased alive on <u>4-22-56</u> , 19 <u>56</u> , and that death occurred at <u>7 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G Saffell</u> M.D.				ADDRESS (Street, city or town, state) <u>Bersters town Md</u> DATE SIGNED <u>4-24-56</u>			
PHYSICIAN'S NAME (Type) <u>James G Saffell MD</u>				<u>Bersters town, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Calwell Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton - Hampstead Md</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>4-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Norm B. Eline</u>	

BUREAU V. B.

APR 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3653

03653

Items 8, 9: G197 film 5/15/56L CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>AS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAME</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 CENTRE AVE</u>		d. STREET ADDRESS <u>I.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LEGNOWSKI</u> Last <u>CARRICK</u>		4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u>
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNK.</u>	
13. FATHER'S NAME <u>WM. LEGNOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>KATHARINE UNK.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONIE</u>	
17. INFORMANT <u>PETER CARRICK, SR.</u>		Address <u>— SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Coronary sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Several yrs.</u> <u>Several yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 4/29</u> , 19 <u>54</u> , to <u>5/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Blath</u>		ADDRESS (Street, city or town, state) <u>454 Eastern Ave. Essex md.</u> DATE SIGNED <u>5/2/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-1-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooke Bradley, Dundalk, Md</u>		24. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

355

BUREAU V. S.

MAY 7 1956

RECEIVED

DATE OF DEATH		PLACE OF DEATH	
MAY 7 1956		BALTIMORE, MARYLAND	
DECEASED'S NAME		SEX	
JOHN J. JONES		MALE	
AGE		RACE	
45		WHITE	
BIRTH DATE		BIRTH PLACE	
MAY 15 1911		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
CLERK		HEART DISEASE	
MANNER OF DEATH		CERTIFICATE NO.	
NATURAL		12345	
SIGNATURE OF DECEASED'S NEXT OF KIN		SIGNATURE OF PHYSICIAN	
JOHN J. JONES		JOHN J. JONES	
RELATIONSHIP		RELATIONSHIP	
SPOUSE		PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 7 1956		MAY 7 1956	

3702

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2120 Firethorn Road				d. STREET ADDRESS 2120 Firethorn Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROSE Middle HILDA Last CHENOWETH				4. DATE OF DEATH Month April Day 27 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1894	
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Peter Gumpman				14. MOTHER'S MAIDEN NAME Katherine E. Otto			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Catherine Overbeck, 202 Woodvale Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 5 YRS							INTERVAL BETWEEN ONSET AND DEATH 11 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN , 19 55 , to APRIL , 19 56 , that I last saw the deceased alive on APRIL 27 , 19 56 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1437 FUSELAGE AVE, BALTO 20, Md 4/27/56							
ACTUAL SIGNATURE Louis Semenovoff				PHYSICIAN'S NAME (Type) LOUIS SEMENOFF M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/30/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR MAY 1 1956	
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2132

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY OF BIRTH		STATE OF BIRTH		COUNTY OF BIRTH	
DATE OF ENTRY INTO STATE		PLACE OF ENTRY		REASON FOR ENTRY	
DATE OF DEPARTURE FROM STATE		PLACE OF DEPARTURE		REASON FOR DEPARTURE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY OF BIRTH		STATE OF BIRTH		COUNTY OF BIRTH	
DATE OF ENTRY INTO STATE		PLACE OF ENTRY		REASON FOR ENTRY	
DATE OF DEPARTURE FROM STATE		PLACE OF DEPARTURE		REASON FOR DEPARTURE	

BUREAU V. S.

MAY 1 1956

RECEIVED

DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY OF BIRTH		STATE OF BIRTH		COUNTY OF BIRTH	
DATE OF ENTRY INTO STATE		PLACE OF ENTRY		REASON FOR ENTRY	
DATE OF DEPARTURE FROM STATE		PLACE OF DEPARTURE		REASON FOR DEPARTURE	

3703

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH o. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2125 St. Lukes Lane</u>		d. STREET ADDRESS <u>2125 St. Lukes Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Emma Augusta Clary</u>		4. DATE OF DEATH <u>April 8 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1868</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Janna Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. La Rue Deuber</u>		Address <u>3605 Howard Park Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio-Vascular Dis.</u> DUE TO 17 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schirrhous Carcinoma of Chest wall & Metast.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>31</u> , to <u>April 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>56</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joshua H. Armacost</u> M.D.		ADDRESS (Street, city or town, state) <u>6419 WINDSOR MILL Rd</u> DATE SIGNED <u>4/8/56</u>	
PHYSICIAN'S NAME (Type) <u>JOSHUA H. ARMACOST</u>		<u>BALTIMORE 7 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Fred'k. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens & Sons - Balto 17</u>		24a. REC'D BY REGISTRAR <u>Mr. H. E. Martin</u> DATE <u>11 1956</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

BUREAU V. S.

APR 11 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03657

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				d. STREET ADDRESS <u>3208 M. Shanley Way</u>								
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>B</u> Last <u>Cleaver</u>				4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1956</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
8. DATE OF BIRTH <u>April 13 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salmon Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>		11. BIRTHPLACE (State or foreign country) _____								
12. CITIZEN OF WHAT COUNTRY? _____				13. FATHER'S NAME <u>John B Cleaver</u>								
14. MOTHER'S MAIDEN NAME <u>Don't Know</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>								
16. SOCIAL SECURITY NO. <u>213-10-7321</u>		17. INFORMANT Address <u>Mrs Lilian Cleaver 3208 M. Shanley</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH _____ </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>A-S-C-V. Disease</u> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> DUE TO (c) _____ </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH _____	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>A-S-C-V. Disease</u>		DUE TO (c) _____	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>A-S-C-V. Disease</u>												
DUE TO (c) _____												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>										
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____								
20f. (City or town) _____		(County) _____		(State) _____								
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>M B Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/27/56</u>								
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried April 30 1956</u>		22b. DATE THEREOF <u>April 30 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Rd</u>								
22d. LOCATION (City, town, or county) <u>Elkridge, Md</u>		(State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>William M Kelly</u>								
ADDRESS <u>Elkridge, Md</u>		24a. REC'D BY REGISTRAR <u>4/28/56</u>		24b. REGISTRAR'S SIGNATURE <u>William M Kelly</u>								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 1 1956

RECEIVED

3704
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN lb <u>37 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>50 Veterans Administration Hospital</u>				d. STREET ADDRESS <u>760 W. Franklin St</u>			
3. NAME OF DECEASED (Type or print) First Middle (COATS) Last <u>ALONZO (NMI) COATES (COSTES)</u>				4. DATE OF DEATH Month Day Year <u>APRIL 10 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1896</u>	9. AGE (In years lost birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Dublin, Georgia</u>	
13. FATHER'S NAME <u>Joseph Coates (Costes)</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VASCULAR NEPHRITIS</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <u>VA</u> attended the deceased from <u>March 4</u> , 19 <u>56</u> , to <u>April 10</u> , 19 <u>56</u> . <u>VA</u> was the attending physician and that death occurred at <u>12:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald D. Mark</u>				M.D. <u>VAH Ft. Howard, Md</u>		DATE SIGNED <u>4/11/56</u>	
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK</u>				M.D. <u>VAH Ft. Howard, Md</u>		DATE SIGNED <u>4/11/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> Charles R. Law Mortuary 802-04 Madison Ave. Balto. Md				24a. REC'D BY REGISTRAR DATE <u>Apr. 14-56</u>		24b. REGISTRAR'S SIGNATURE <u>W. P. Fester</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. JONES		Male		37		1918		Baltimore, Maryland	
MARRIAGE		MARRIED		DATE		PLACE		BY WHOM	
None		None		None		None		None	
OCCUPATION		None		None		None		None	
None		None		None		None		None	
CAUSE OF DEATH		None		None		None		None	
None		None		None		None		None	
MANNER OF DEATH		None		None		None		None	
None		None		None		None		None	
SIGNATURE OF PHYSICIAN		None		None		None		None	
None		None		None		None		None	
SIGNATURE OF REGISTRAR		None		None		None		None	
None		None		None		None		None	

BUREAU V. S.
RECEIVED
 APR 17 1956

3705

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS 3321 Chestnut Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDWARD Middle J. Last COLLISON				4. DATE OF DEATH Month April Day 28 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/25	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 30 Days 30 Hours 30 Min. 30		IF UNDER 24 HRS. Months 30 Days 30 Hours 30 Min. 30			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver				10b. KIND OF BUSINESS OR INDUSTRY Calvert Oil Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Roland Collison				14. MOTHER'S MAIDEN NAME Anna Alberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II				16. SOCIAL SECURITY NO. 217 16 6599			
17. INFORMANT CLIN.REC.VET.ADM.HOSP., FT. HOWARD, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOMA RIGHT CEREBRAL HEMISPHERE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 193X DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 193X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 27 , 19 56 , to April 28 , 19 56 , and that death occurred at 10:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland			
DATE SIGNED 4/29/56							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-3-56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc.				ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR DATE 7 1956	
24b. REGISTRAR'S SIGNATURE Lawson L. Farley							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4. 7

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1. *Salmonella* *typhimurium* *disenteriae*

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2010-2011

Group

BUREAU A

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RECEIVED
JAN 2 1956

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APR 3 1956
BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03661
20

3707 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1mo. 9days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle O. Last Corey				4. DATE OF DEATH Month April Day 24 , Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-1897	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Md. Ship Bldg. Co.	
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Corey				14. MOTHER'S MAIDEN NAME Dora ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 2-3-81-2699			
17. INFORMANT Records Spring Grove State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic interstitial pneumonia, left lung DUE TO (c) Carcinoma apex of right lung (metastatic)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-15 , 19 56 , to 4-24 , 19 56 , that I last saw the deceased alive on 4-24 , 19 56 , and that death occurred at 12:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachsler M.D. Spring Grove State Hospital 4-24-56							
ACTUAL SIGNATURE Stella Wachsler							
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		April 27/56		Green Haven		Green Haven, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Harrison				ADDRESS Green Haven, Md.			
24. REC'D BY REGISTRAR APR 30 1956				25. REGISTRAR'S SIGNATURE J. E. Harry			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
AGE [Illegible]		SEX [Illegible]	
RACE [Illegible]		MARITAL STATUS [Illegible]	
PLACE OF BIRTH [Illegible]		CITY OF BIRTH [Illegible]	
CITY OF DEATH [Illegible]		COUNTY OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL ATTENDANCE [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF JUDGE [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

BUREAU V. S.

APR 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G196 5-1-56

3708

CERTIFICATE OF DEATH

Reg. Dist. No.

03662

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Spring Grove State Hospital</i>		d. STREET ADDRESS <i>1444 Boyle St.</i>	
3. NAME OF DECEASED (Type or print) <i>ELLA</i> First <i>Louise</i> Middle <i>Craig</i> Last		4. DATE OF DEATH Month <i>4</i> Day <i>29</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/6/1880</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Rice</i>		14. MOTHER'S MAIDEN NAME <i>Mary Craft</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Family - Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive arteriosclerosis of heart & brain</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <i>General arteriosclerosis</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>o. n.</i> Month <i>19</i> Day <i>19</i> Year <i>1956</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/29</i> , 19 <i>56</i> , to <i>4/29</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>5/20</i> , 19 <i>56</i> , and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Dr. David Kravitz</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes</i>		24a. REC'D BY REGISTRAR DATE <i>30 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>C. E. ...</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910	
5. PLACE OF BIRTH New York, N.Y.		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF DEATH April 28, 1956	
9. CAUSE OF DEATH Myocardial Infarction		10. PLACE OF DEATH Home		11. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. DATE OF INTERMENT April 29, 1956		14. PLACE OF INTERMENT St. John's Cemetery		15. SIGNATURE OF MINISTER Rev. J. H. Smith		16. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. J. H. Jones	
17. DATE OF REGISTRATION April 29, 1956		18. PLACE OF REGISTRATION Bureau of Vital Statistics		19. SIGNATURE OF REGISTRAR J. H. Smith		20. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. J. H. Jones	

BUREAU V. S.

APR 30 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03663

3709 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		LENGTH OF STAY (in this place) 4 YEARS		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		370114	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MASONIC HOME				STREET ADDRESS 106 S. GILMORE ST		(If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) WILLIAM JOHN CREW				4. DATE OF DEATH (Month) (Day) (Year) 4 5 19 56			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 11-1-1859	9. AGE last birthday 96 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY B+O R.R.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME WILLIAM JAMES CREW				14. MOTHER'S MAIDEN NAME SUSANNA AUSTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S ADDRESS FRANK L. SMITH, JR COCKEYSVILLE, MD			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) Arteriosclerotic Cardio Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH over 4 yrs			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 52 , 19 52 , to April 56 , 19 56 , that I last saw the deceased alive on 4 April 1956 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.							
SIGNATURE Walter T. Cook				M.D. Cockeysville Md		DATE SIGNED 5 April 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-9-56		NAME OF CEMETERY OR CREMATORY Louder Pk		LOCATION (City, town, or county) (State) BALTO MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Frank Smith		25. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc		ADDRESS 1217 St Paul	
DATE APR 9 1956							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2

BUREAU V.

APR 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03664

3655

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> STREET ADDRESS (If rural give location) <u>216 St Helena Ave</u>			
3. NAME OF DECEASED (First) <u>Sarah</u> (Middle) <u>Crooks</u> (Last) (Type or Print)				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Nov 12 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Mary A Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Leroy Crooks 216 St Helena Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic-Cardio-Vas. Dis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Accident</u>				24 hrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10:00</u> M. <u>1956</u>		21e. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 21, 1956</u> , to <u>April 27, 1956</u> , that I last saw the deceased alive on <u>April 26, 1956</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William M. Kelly</u>				ADDRESS (Street, city, town, state) <u>6800 Mockingbird Lane - Dundalk - Md 2122</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>removal</u>		DATE THEREOF <u>April 27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cem</u>		LOCATION (City, town, or county) (State) <u>Akron Ohio</u>	
24. REC'D BY REGISTRAR DATE <u>4/28/56</u>		REGISTRAR'S SIGNATURE <u>William M. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave</u>			

11. **BOULEVARD**

BUREAU V.

MAY 1 1956

11

70

01592

10/15/2015 12:43:56 PM

BUREAU V. S.

MAY 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3710

CERTIFICATE OF DEATH

036653w

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Maryland	
c. LENGTH OF STAY IN 1b 1yr5mth20dys		d. STREET ADDRESS 1440 Ammendale Road P. O. Box 452 - Beltsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jean= Middle Pownall Last Curran		4. DATE OF DEATH Month April Day 17 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1884
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Harrison	
14. MOTHER'S MAIDEN NAME Emma Louisa Pownall		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Diabetes Mellitus DUE TO (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19 54 to April 17, 1956 , that I last saw the deceased alive on April 17, 1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachler M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-18-56	
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/1956	22c. NAME OF CEMETERY OR CREMATORY George Washington Cem.	22d. LOCATION (City, town, or county) Riggs Rd. Extd. Hyattsville, Pr. Geo. Co.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 5801 Cleveland Ave.		24a. REC'D BY REGISTRAR DATE 20 1956	24b. REGISTRAR'S SIGNATURE P. O. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

RECEIVED

APR 20 1956

BUREAU V. S.

3711

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 66 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS 2114 Division Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HENRY Middle CURRY Last CURRY				4. DATE OF DEATH Month April Day 24 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1896	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 24 Days 24 Hours 1956		IF UNDER 24 HRS. Months 24 Days 24 Hours 1956			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) White Stone, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Buck Curry				14. MOTHER'S MAIDEN NAME Sarah Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 214-14-7034		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0.23X (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SYPHILITIC CARDIOVASCULAR DISEASE				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. VA				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from February 18, 1956 to April 24, 1956 that death occurred on the date stated above, and that death occurred at 12:40 PM from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/25/56							
ACTUAL SIGNATURE Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D. Chief, Medical VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/30/1956		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT'L CEM.		22d. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES G. COOPER -512 CARROLLTON AV.				24a. REC'D BY REGISTRAR APR 27 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Larkins	

512 N. Carrollton Ave., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. S.

APR 27 1956

RECEIVED

DR. J. D. COOPER - 515 CARROLLTON AV.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3712

CERTIFICATE OF DEATH

03667

Reg. Dist. No. 2

Item 18 Film G204 9-28-56 sms

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>55 Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>55 Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 Midhurst Rd.</u>		STREET ADDRESS (If rural give location) <u>102 Midhurst Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>DORIS P. DALY</u>		<u>April 25, 19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 23, 1917</u>
9. AGE last birthday: <u>38</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>N. Y.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Cirus V. Peck</u>		14. MOTHER'S MAIDEN NAME: <u>- Boyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Mr. Warren B. Daly - 102 Midhurst Rd.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1955</u> to <u>April 25 1956</u> that I last saw the deceased alive on <u>April 24, 1956</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harry Z. Klempfner</u>		DATE SIGNED <u>M.D. 1101 N. Calvert St. Bldg. 2. 4/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>4/25/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cem.</u>		LOCATION (City, town, or county) (State) <u>Rochester, N. Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-25-56</u>		REGISTRAR'S SIGNATURE <u>Dr. H. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Chas. J. Pickens</u>		ADDRESS <u>1700 - Balto 17th</u>	

3713

CERTIFICATE OF DEATH

03668

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1602 McKean Ave.,</u>			
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>(NMI)</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/93</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shady Side, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Richard Davis</u>			
14. MOTHER'S MAIDEN NAME <u>Susan Turner</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>			
16. SOCIAL SECURITY NO. <u>214-05-2340</u>				17. INFORMANT <u>Clin. Rec. Vets. Adm. Hosp., Fort Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, RIGHT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>56</u> , to <u>April 15</u> , 19 <u>56</u> , that I saw the deceased alive on <u>April 12</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Francis G. Dickey</u> M.D. <u>VAH Fort Howard, Md.</u> <u>4/16/56</u> PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY, M.D.</u> <u>VAH Fort Howard, Md</u> <u>4/16/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> M <u>Charles R. Law Mortuary 802 Madison Ave., Balto.</u>				24a. REC'D BY REGISTRAR <u>DATE</u> <u>Apr. 19-56</u> 24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

APR 23 1956

RECEIVED

3667

CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Statenburg</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Statenburg</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Statenburg</u> d. STREET ADDRESS <u>1929 Woodside Ave</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Juliana Marie Wayhuff</u> First Middle Last				4. DATE OF DEATH <u>Apr 10</u> Month Day Year					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16 1878</u> yrs. 77		9. AGE (In years lost birthday) <u>77</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scrapper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beer, Steeler</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Wayhuff</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Sauer</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-09-9034</u>		17. INFORMANT <u>Patricia Wayhuff</u> Address <u>1929 Woodside Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Jan 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1949</u> to <u>Apr 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 10</u> , 19 <u>56</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Willard S. Parson</u> M.D.				ADDRESS (Street, city or town, state) <u>1711 Selma Ave Balto-27-Md</u> DATE SIGNED <u>Apr 27 1956</u>					
PHYSICIAN'S NAME (Type) <u>WILLARD S. PARSON</u>				ADDRESS <u>1711 Selma Ave Balto-27-Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 12 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Co Md.</u>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Q. Milled Wayhuff Wingard, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>APR 12 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kieffer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in payment within 72 hours after death.

03670

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3714

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Extensiveville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Home</u>		STREET ADDRESS (If rural, give location) <u>100 E. Cross St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Elizabeth</u> (Middle) <u>DECK</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>5</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/10/1889</u>
9. AGE last birthday <u>67</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Fritz</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Krietie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Charles Deck 100 E. Cross St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

447X
Immediate cause (a) Pulmonary EdemaAntecedent cause(s) (b) 1/4 pulmonary & Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

8 hrs

unknown

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Rt. hemiplegia

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

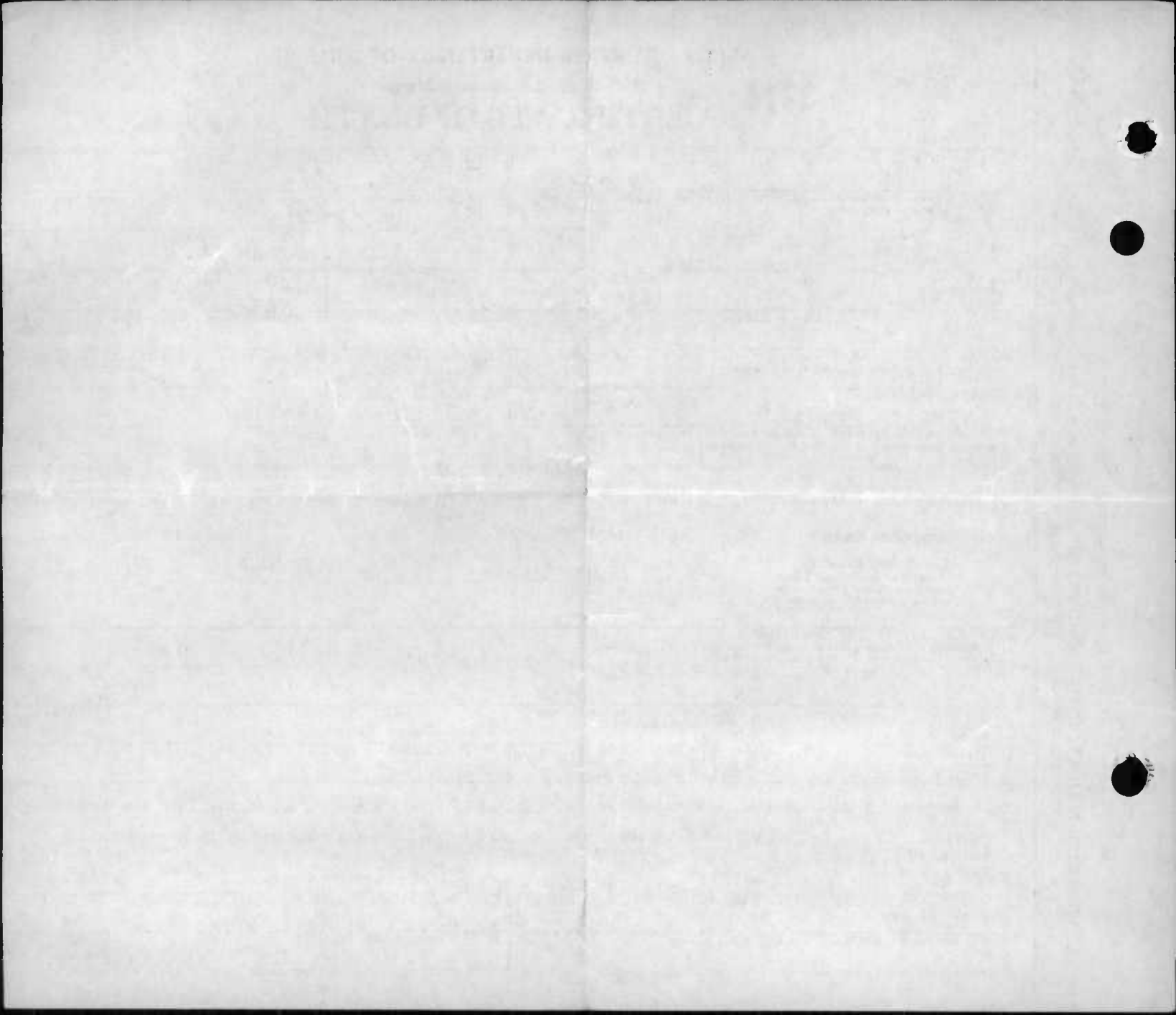
22. I hereby certify that I attended the deceased from Feb 11, 1952, to Apr 5, 1952, that I last saw the deceasedalive on 4/5, 1952, and that death occurred at 1:12 P.M., from the causes and on the date stated above.SIGNATURE John F. Denny (Degree or title) ADDRESS 4605 Edmondson and Balls DATE SIGNED 29 4/6/52

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/9/56</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>4-9-56</u>	REGISTRAR'S SIGNATURE <u>John F. Denny</u>	24. FUNERAL DIRECTOR ADDRESS <u>JOHN F. DENNY, INC. 715 Light St.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3715

CERTIFICATE OF DEATH

03671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Milford Gardens		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford Gardens	
c. LENGTH OF STAY IN 1b 3 Yrs.		d. STREET ADDRESS 3412 Mayfair Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3412 Mayfair Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie K. Middle Depser Last		4. DATE OF DEATH Month April Day 17 Year 19 56.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1875
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles Herbold		14. MOTHER'S MAIDEN NAME Mary Dietz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT John R. Herbold		Address 3412 Mayfair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days 30 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 19 52 to 4/17 , 19 56 that I last saw the deceased alive on 4/17 , 19 56 , and that death occurred at 540 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin Pierpont		M.D. 8204 Gibeaux Rd. Balt 7, Md. 4/18/56	
PHYSICIAN'S NAME (Type) E. L. Pierpont			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-21-1956	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong		ADDRESS 3207 N. North Ave.	
24a. REC'D BY REGISTRAR DATE 23 1956		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John H. Brown		Male		45		May 15, 1910		Baltimore, Md.		Baltimore, Md.		Heart Disease		May 20, 1956		10:00 AM		Home		J. H. Brown		J. H. Brown	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Last Medical Examination		Manner of Death		Certified by		Date of Certification		Signature of Certifier		Signature of Registrar		Signature of Physician	
Teacher		Married		High School		Roman Catholic		Hypertension		May 15, 1956		Natural		J. H. Brown		May 20, 1956		J. H. Brown		J. H. Brown		J. H. Brown	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Certifier		Signature of Physician		Signature of Registrar		Signature of Certifier		Signature of Physician		Signature of Registrar		Signature of Certifier		Signature of Physician	
John H. Brown		John H. Brown		J. H. Brown		J. H. Brown		J. H. Brown		J. H. Brown		J. H. Brown		J. H. Brown		J. H. Brown		J. H. Brown		J. H. Brown		J. H. Brown	

BUREAU V. S.

APR 23 1956

RECEIVED

COMPTON

THIS IS A COPY OF THE ORIGINAL RECORD OF THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3716

CERTIFICATE OF DEATH

Reg. Dist. No. 0367230

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
c. LENGTH OF STAY IN TB 48 yrs.				d. STREET ADDRESS 628 Aldershot Rd			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 628 Aldershot Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frances L. DiBernardo or Bernard				4. DATE OF DEATH April 15/56			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1907	
9. AGE (In years last birthday) 49		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10b. KIND OF BUSINESS OR INDUSTRY Cambridge Tailoring (Italy)			
13. FATHER'S NAME late Vito Laduca				14. MOTHER'S MAIDEN NAME Anna Passalacqua			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215 01 8144			
17. INFORMANT Stephen DiBernardo				Address 628 Aldershot Rd Catonsville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Acute leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 mos DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Feb 15 , 19 56 , to April 15 , 19 56 , that I last saw the deceased alive on April 14 , 19 56 , and that death occurred at 10:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard Gaffe				ADDRESS (Street, city or town, state) 3101 W. Baltimore St, Baltimore, Md 416/56			
PHYSICIAN'S NAME (Type) Harry A. Witzke				DATE SIGNED APR 18 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 18/56		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry A. Witzke				ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR APR 18 1956	
24b. REGISTRAR'S SIGNATURE J. E. Harris							

RECEIVED

APR 18 1956

BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6947

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>24 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>EMANUEL</i> Middle <i>DIAZ</i> Last		4. DATE OF DEATH Month <i>April</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3 May 1883</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seaman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Spain</i>		12. CITIZEN OF WHAT COUNTRY? <i>Spain</i> ✓	
13. FATHER'S NAME <i>Joseph Diaz</i>		14. MOTHER'S MAIDEN NAME <i>Carlotta Diaz (?)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Spring Grove Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Broncho pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>unknown</i> <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>9</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>23 May</i> 1955, to <i>24 April</i> 1956, that I last saw the deceased alive on <i>24 April</i> 1956, and that death occurred at <i>5:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>T. Shone Williams</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Spring Grove State Hospital 4-25-56</i>	
PHYSICIAN'S NAME (Type) <i>T. G. WILLYMS</i>		<i>Catonsville 28, Ind.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Anatomy Bld. of Md</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <i>AUG 7 '57</i>	24b. REGISTRAR'S SIGNATURE <i>Overman</i>

MEDICAL CERTIFICATION

THIS CERTIFICATE WAS FORWARDED TO US LATE FROM THE ANATOMY BOARD.

APPARENTLY IT HAD BEEN MISLAID AMONG SOME PAPERS AND IT WAS

JUST FOUND BY A NEW SECRETARY. WE WERE NOT AWARE OF THE DEATH

BECAUSE NO SERVICE WAS REQUIRED. MNB 8/8/57

BUREAU V. S.

1957 AUG 8

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03673

3717 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Balto</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		LENGTH OF STAY (In this place) <i>Life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		X	
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>114 Smithwood Ave</i>				STREET ADDRESS (If rural give location) <i>114 Smithwood Ave</i>			
3. NAME OF DECEASED (Type or Print) <i>DANIEL</i> (First) <i>DIEHL</i> (Middle) <i>MANIV</i> (Last)				4. DATE OF DEATH (Month) <i>4</i> (Day) <i>6</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>7-6-1887</i>	9. AGE last birthday <i>68</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frederick Diehlmann</i>				14. MOTHER'S MAIDEN NAME <i>Beckman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>2</i>		17. INFORMANT & ADDRESS <i>Mrs. Cornelis Diehlmann</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <i>Left heart failure</i>						<i>2 weeks</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>ASCVD - mitral regurgitation</i>						<i>Unknown</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2-28</i> , 19 <i>53</i> , to <i>7-6</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3-31</i> , 19 <i>56</i> , and that death occurred at <i>1:15 P</i> .M, from the causes and on the date stated above.							
SIGNATURE <i>Stephen Lee Magness</i>		M.D. <i>908 Frederick Rd Catonsville Md</i>		DATE SIGNED <i>4-8-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i>		DATE THEREOF <i>4/9/56</i>		NAME OF CEMETERY OR CREMATORY <i>Louise Park Cemetery Balto Co</i>		LOCATION (City, town, or county) (State) <i>Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J.E. Harry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Nabe & Son - Catonsville - Md</i>		ADDRESS	
DATE <i>4/10/56</i>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03674

3718 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <u>BALTO</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u> LENGTH OF STAY (In this place) <u>9 YRS.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3129 CORNWALL Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> STREET ADDRESS (If rural give location) <u>3129 CORNWALL Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARIAN BURKE DIGGINS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APR. 10 1956</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WH.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN 29, 1898</u>
9. AGE last birthday <u>58</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL BURKE</u>		14. MOTHER'S MAIDEN NAME <u>CATHARINE HILL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO NIE</u>	
17. INFORMANT & ADDRESS <u>C.H. DIGGINS - SAME.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>	
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>—</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>1125 S. KENNEDY Baltimore Md.</u> DATE SIGNED <u>APR 11 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APR 13, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR <u>APR 11 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint, illegible text]

2. SEX: [Faint, illegible text]

3. AGE: [Faint, illegible text]

4. DATE OF BIRTH: [Faint, illegible text]

5. PLACE OF BIRTH: [Faint, illegible text]

6. DATE OF DEATH: [Faint, illegible text]

7. PLACE OF DEATH: [Faint, illegible text]

8. CAUSE OF DEATH: [Faint, illegible text]

9. MANNER OF DEATH: [Faint, illegible text]

10. SIGNATURE OF PHYSICIAN: [Faint, illegible text]

11. SIGNATURE OF REGISTRAR: [Faint, illegible text]

12. SIGNATURE OF WITNESS: [Faint, illegible text]

13. SIGNATURE OF DECEASED: [Faint, illegible text]

14. SIGNATURE OF NEXT OF KIN: [Faint, illegible text]

15. SIGNATURE OF CLERK: [Faint, illegible text]

16. SIGNATURE OF CHURCH CLERK: [Faint, illegible text]

17. SIGNATURE OF BURIAL CLERK: [Faint, illegible text]

18. SIGNATURE OF INTERMENT CLERK: [Faint, illegible text]

19. SIGNATURE OF FUNERAL HOME: [Faint, illegible text]

20. SIGNATURE OF CEMETERY: [Faint, illegible text]

21. SIGNATURE OF BURIAL SOCIETY: [Faint, illegible text]

22. SIGNATURE OF OTHER: [Faint, illegible text]

23. SIGNATURE OF DECEASED: [Faint, illegible text]

24. SIGNATURE OF NEXT OF KIN: [Faint, illegible text]

25. SIGNATURE OF CLERK: [Faint, illegible text]

26. SIGNATURE OF CHURCH CLERK: [Faint, illegible text]

27. SIGNATURE OF BURIAL CLERK: [Faint, illegible text]

28. SIGNATURE OF INTERMENT CLERK: [Faint, illegible text]

29. SIGNATURE OF FUNERAL HOME: [Faint, illegible text]

30. SIGNATURE OF CEMETERY: [Faint, illegible text]

RECEIVED

BUREAU V. S.

APR 11 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03675

2411 N. Charles Street, Baltimore

3656

CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 9, Film 0195 4-19-56 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Dundalk</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 York Way</u>		STREET ADDRESS <u>Dundalk Md</u>	
3. NAME OF DECEASED (First) <u>Julia</u> (Middle) <u>Dolan</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>10</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-1-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>75</u> <u>76</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. COUNTRY OF BIRTH <u>U S A</u>	
13. FATHER'S NAME <u>Dennis Mc Charty</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Pierre Dolan 15 York Way Dundalk 22</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-2, 1956, to 4-10, 1956, that I last saw the deceasedalive on 4-10, 1956, and that death occurred at 1:30 pm m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE/REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

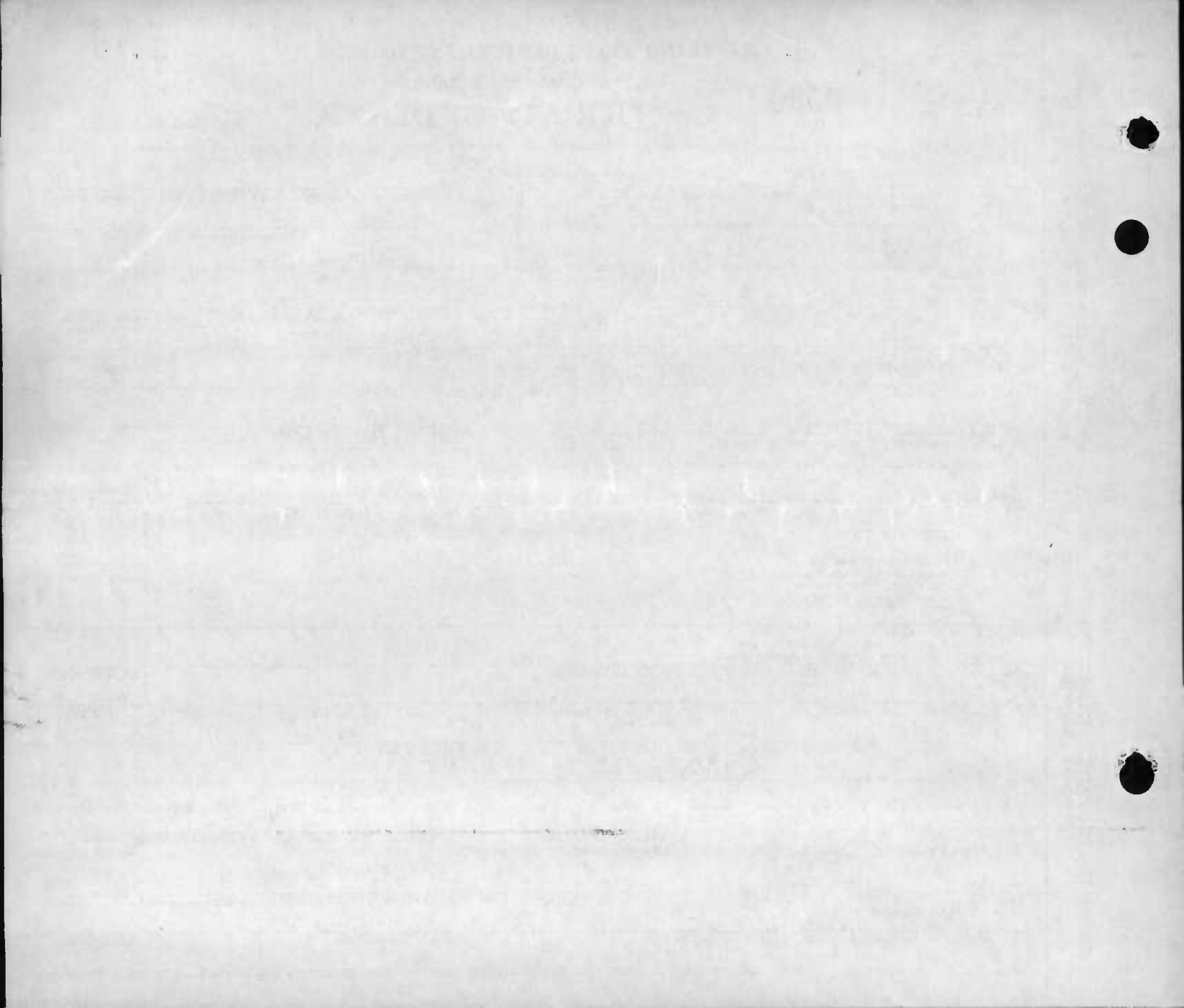
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Page 4 of 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3719

CERTIFICATE OF DEATH

03676 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home		d. STREET ADDRESS Ebenezer Rd. Box 237 Route 16	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle E. Last Dougherty		4. DATE OF DEATH Month April Day 30 , Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Martin		14. MOTHER'S MAIDEN NAME Margaret Coyle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret Eurice-Box 245 Route 16, Zone 20		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis - 10 years INTERVAL BETWEEN ONSET AND DEATH 72 hours 20 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 26, 1955, to April 30, 1956 , that I last saw the deceased alive on April 28, 1956 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5/1/56 DATE SIGNED			
ACTUAL SIGNATURE Harvey L. Fuller		M.D.	
PHYSICIAN'S NAME (Type) Harvey L. Fuller		Ridge Road, Baltimore 6, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 3, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR 5/2/56		DATE Edith Hurley	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAY 3 1956

RECEIVED

CERTIFICATE OF DEATH

03677

Reg. Dist. No. 30 600

3720

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Balto.		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in the Pines-Fusting Ave.				STREET ADDRESS (If rural give location) 1602 Lochwood Rd.			
3. NAME OF DECEASED (Type or Print) MARGARET C. DOUGHERTY				4. DATE OF DEATH (Month) (Day) (Year) April 22, 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Nov. 5, 1880	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary Rtd		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Owen Daugherty				14. MOTHER'S MAIDEN NAME Ann Kane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 712-16-1533		17. INFORMANT & ADDRESS Mrs. Ann Lynch - 1602 Lochwood Rd.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Atherosclerotic Degenerative C.V. Disease							
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Nephritis with Anemia						1 to 2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension. Cirrhosis of Liver.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Severe Secondary Anemia.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 9, 19 55 , to 22 Apr., 19 56 , that I last saw the deceased alive on 22 Apr., 19 56 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
SIGNATURE Joseph E. Muse Jr.				ADDRESS (Street, city, town, state) 5 West 29th St. Balto. 18 Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 4/23/56		NAME OF CEMETERY OR CREMATORY Cathedral Cem.		LOCATION (City, town, or county) (State) Scranton, Pa.	
24. REC'D BY REGISTRAR DR 23 1956		REGISTRAR'S SIGNATURE J. E. Harry		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickers & Sons - Balt		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE WHERE DEATH OCCURRED

PLACE OF DEATH

DATE OF DEATH

MARYLAND

DECEASED

AGE

DECEASED

DECEASED

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BUREAU V. S.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03678
403721
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4014 Perry Hall Rd</u>		d. STREET ADDRESS <u>4014 Perry Hall Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>Dreyer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 20, 1871</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Gerhardt Dreyer</u>		14. MOTHER'S MAIDEN NAME <u>Angela Hugelmeier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Paul W. Lacey</u>	
17. INFORMANT <u>Paul W. Lacey</u>		Address <u>4014 Perry Hall Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Dis.</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 Mo.</u> <u>9 yrs.</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1936</u> to <u>April 29, 1956</u> , that I last saw the deceased alive on <u>April 29, 1956</u> , and that death occurred at <u>4:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		DATE SIGNED <u>4/30/56</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens Cen</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>DATE 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICER	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF MINISTERS		23. SIGNATURE OF MUSICIANS		24. SIGNATURE OF FLORISTS	
25. SIGNATURE OF COFFIN MAKERS		26. SIGNATURE OF CARRIAGE DRIVERS		27. SIGNATURE OF BURIAL OFFICERS	
28. SIGNATURE OF DECEASED'S FRIENDS		29. SIGNATURE OF DECEASED'S ENEMIES		30. SIGNATURE OF DECEASED'S NEIGHBORS	
31. SIGNATURE OF DECEASED'S RELATIVES		32. SIGNATURE OF DECEASED'S COUSINS		33. SIGNATURE OF DECEASED'S AUNT	
34. SIGNATURE OF DECEASED'S UNCLE		35. SIGNATURE OF DECEASED'S GRANDFATHER		36. SIGNATURE OF DECEASED'S GRANDMOTHER	
37. SIGNATURE OF DECEASED'S GREAT FATHER		38. SIGNATURE OF DECEASED'S GREAT MOTHER		39. SIGNATURE OF DECEASED'S GREAT UNCLE	
40. SIGNATURE OF DECEASED'S GREAT AUNT		41. SIGNATURE OF DECEASED'S GREAT GRANDFATHER		42. SIGNATURE OF DECEASED'S GREAT GRANDMOTHER	
43. SIGNATURE OF DECEASED'S GREAT GREAT FATHER		44. SIGNATURE OF DECEASED'S GREAT GREAT MOTHER		45. SIGNATURE OF DECEASED'S GREAT GREAT UNCLE	
46. SIGNATURE OF DECEASED'S GREAT GREAT AUNT		47. SIGNATURE OF DECEASED'S GREAT GREAT GRANDFATHER		48. SIGNATURE OF DECEASED'S GREAT GREAT GRANDMOTHER	
49. SIGNATURE OF DECEASED'S GREAT GREAT GREAT FATHER		50. SIGNATURE OF DECEASED'S GREAT GREAT GREAT MOTHER		51. SIGNATURE OF DECEASED'S GREAT GREAT GREAT UNCLE	
52. SIGNATURE OF DECEASED'S GREAT GREAT GREAT AUNT		53. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GRANDFATHER		54. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GRANDMOTHER	
55. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT FATHER		56. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT MOTHER		57. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT UNCLE	
58. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT AUNT		59. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GRANDFATHER		60. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GRANDMOTHER	
61. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT FATHER		62. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT MOTHER		63. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT UNCLE	
64. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT AUNT		65. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GRANDFATHER		66. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GRANDMOTHER	
67. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT FATHER		68. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT MOTHER		69. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT UNCLE	
70. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT AUNT		71. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GRANDFATHER		72. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GRANDMOTHER	
73. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT FATHER		74. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT MOTHER		75. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT UNCLE	
76. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT AUNT		77. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDFATHER		78. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDMOTHER	
79. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT FATHER		80. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT MOTHER		81. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT UNCLE	
82. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT AUNT		83. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDFATHER		84. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDMOTHER	
85. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT FATHER		86. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT MOTHER		87. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT UNCLE	
88. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT AUNT		89. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDFATHER		90. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDMOTHER	
91. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT FATHER		92. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT MOTHER		93. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT UNCLE	
94. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT AUNT		95. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDFATHER		96. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDMOTHER	
97. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT FATHER		98. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT MOTHER		99. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT UNCLE	
100. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT AUNT		101. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDFATHER		102. SIGNATURE OF DECEASED'S GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GREAT GRANDMOTHER	

RECEIVED
MAY 1 1956
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03679										
3722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY A.A. County					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			c. LENGTH OF STAY IN 1b 2 yrs. plus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Spring Grove State Hospital					d. STREET ADDRESS 169 King George Street					
3. NAME OF DECEASED (Type or print) First Erma Middle A. Last Duvall					4. DATE OF DEATH Month April Day 15 Year 19 56					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-1877		9. AGE (In years last birthday) 78 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George Tydings Henry Q.					14. MOTHER'S MAIDEN NAME Alvarda Stallings					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records- Spring Grove					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular Disease (a), stating the underlying cause lost, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Geo. S.M. Kieffer M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) George S.M. Kieffer					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff			22d. LOCATION (City, town, or county) (State) Annapolis Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor					ADDRESS San Annapolis Md		24a. REC'D BY REGISTRAR DATE 4-16-56		24b. REGISTRAR'S SIGNATURE T. E. Barry	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page One

Name of Deceased		Sex		Age		Date of Death	
Residence		Occupation		Cause of Death		Manner of Death	
Place of Death		Physician		Hospital		Coroner	
Medical History		Physical Examination		Mental Examination		Autopsy	
Laboratory Tests		X-ray		Microscopic		Toxicology	
Other		Other		Other		Other	

BUREAU V. 2

APR 17 1956

RECEIVED

3723

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catonsville Convalescent Home</u>		d. STREET ADDRESS <u>1403 Valleyview Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Luntina</u> Middle <u>Etz</u> Last <u>Etz</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> , Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ludwig Simokat</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Schaefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Charlotte L. Netzer</u>		Address <u>1403 Valleyview</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pernicious Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1956</u> , to <u>April 24, 1956</u> , that I last saw the deceased alive on <u>April 24, 1956</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joshua H. Armacost</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>6419 Windsor Mill Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>JOSHUA H. ARMACOST</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Avenue</u>	
24a. REC'D BY REGISTRAR <u>APR 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>T. E. Harry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 1

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES H. BROWN		Male		45		White		1880		Baltimore, Md.	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR	
April 27, 1950		10:30 AM		Home		Heart Disease		Natural		J. H. Smith	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF MINISTER		17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF MINISTER		23. SIGNATURE OF BURIAL OFFICIAL		24. SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 27 1950

RECEIVED

RECEIVED
MAY 1 1950
BALTIMORE, MD.

3724

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARTFORD PARK</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1742 WENTWORTH RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>B</u> Last <u>FAMOUS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/20/1900</u>	
9. AGE (In years last birthday) yrs. <u>55</u>		10. UNDER 1 YEAR Months <u>4</u> Days <u>24</u> Hours <u>19</u> Min. <u>56</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINISTS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ST5 AUTOMOTIVE CO</u>			
13. FATHER'S NAME <u>PARKER FAMOUS</u>				14. MOTHER'S MAIDEN NAME <u>ROSALIE SWANNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-05-7046</u>		17. INFORMANT <u>Euphemia FAMOUS</u>		Address <u>1742 WENTWORTH RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>1939</u> , 19____, to <u>4-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-23</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. L. Ewald, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>36 York Court - Baltimore 18, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. L. Ewald, Jr.</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-28-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS & SON</u>				ADDRESS <u>8802 HARTFORD RD.</u>		24a. REC'D BY REGISTRAR <u>APR 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film 6196 5-1-56 et

03682

CERTIFICATE OF DEATH

Reg. Dist. No. 31

3725

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale md. #7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home (As in #2)</u>				d. STREET ADDRESS <u>3619 Clifmar Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Ella L. Farmer</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19/1866</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk Vir.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>Francis H. Beachum</u>				14. MOTHER'S MAIDEN NAME <u>Annie Kohn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Nellie H. Stanig</u>				Address <u>3619 Clifmar Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident -</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. disease - Chronic</u> (c) <u>Coronary Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County) (State)			
21. I certify that I attended the deceased from <u>MAY - 1</u> , 1953, to <u>APRIL 24</u> , 1956, that I last saw the deceased alive on <u>APRIL 24</u> , 1956, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>				ADDRESS (Street, city or town, state) <u>3601 Clifmar Rd - Balt 7 -</u>			
PHYSICIAN'S NAME (Type) <u>Thomas E. Wheeler</u>				DATE SIGNED <u>4/25/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Mth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>New Kent Co. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herwig Sons</u>				ADDRESS <u>2024 Orleans St. Balto. 31 md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Martin</u>				DATE <u>25 1956</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

11

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]	
15. SIGNATURE OF REGISTRAR [Faint text]		16. SIGNATURE OF CLERK [Faint text]	
17. SIGNATURE OF JUDGE [Faint text]		18. SIGNATURE OF SHERIFF [Faint text]	
19. SIGNATURE OF DISTRICT ATTORNEY [Faint text]		20. SIGNATURE OF PROSECUTOR [Faint text]	
21. SIGNATURE OF DEFENSE COUNSEL [Faint text]		22. SIGNATURE OF JURY [Faint text]	
23. SIGNATURE OF COURT REPORTER [Faint text]		24. SIGNATURE OF COURT CLERK [Faint text]	
25. SIGNATURE OF COURT STENOGRAPHER [Faint text]		26. SIGNATURE OF COURT INTERPRETER [Faint text]	
27. SIGNATURE OF COURT TRANSLATOR [Faint text]		28. SIGNATURE OF COURT TRANSLITER [Faint text]	
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99. SIGNATURE OF COURT TRANSLITER [Faint text]		100. SIGNATURE OF COURT TRANSLITER [Faint text]	

BUREAU V. A.

APR 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03683

3726

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 39

Item 8, File # 95-1-16-56 et

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	
TOWN <u>201st</u>		TOWN <u>Phoenix</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #1 Box 34</u>		STREET ADDRESS (If rural, give location) <u>Box #34 RFD #1</u>	
3. NAME OF DECEASED (First) <u>Frederick</u> (Middle) <u>Dan</u> (Last) <u>Flemke</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>2</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lift operator - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Quarry</u>	9. AGE last birthday <u>1889, 66</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Family Records</u>	
17. INFORMANT AND ADDRESS <u>Family Records</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion (occlusion)Antecedent cause(s) (b) Sudden

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

21. REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTERAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial Apr. 4, 1956 Fairview Methodist Cem. Sunnybrook, Balto. Co., Md.
4/5/56 M. Elizabeth Gorsuch John Burner, Sr., Towson, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3727 CERTIFICATE OF DEATH

03684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Liberty Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Ann</u> Last <u>Flynn</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Kathreine Kroger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles L. Flynn, Liberty Rd., Randallstown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fernicious Anemia, cerebral</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>hemorrhage</u> DUE TO (c) <u>Cardio-Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>4/21/1956</u> , that I last saw the deceased alive on <u>4/21/1956</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm E. Martin</u>		ADDRESS (Street, city or town, state) <u>Randallstown Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm E. Martin</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 24, '56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>	22d. LOCATION (City, town, or county) (State) <u>Harrisonville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell, Pikesville</u>		24a. REC'D BY REGISTRAR DATE <u>4/22/56</u>	24b. REGISTRAR'S SIGNATURE <u>Wm E. Martin</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03685

3728

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

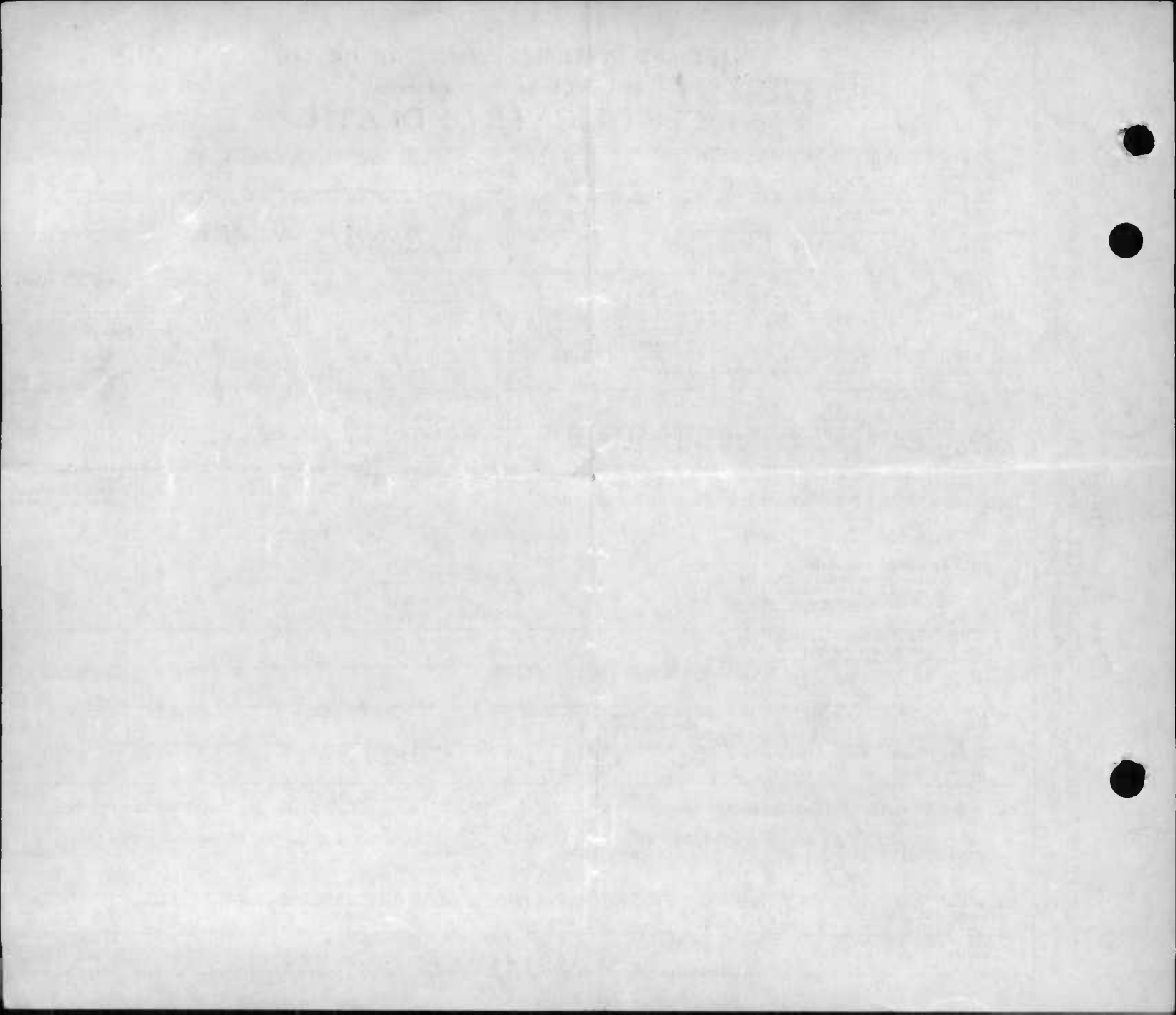
Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>206 S. Eden St.</u> 3701-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Home</u>		STREET ADDRESS (If rural, give location) <u>Baltimore, Md.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <u>Lucie A. Fritz</u> <u>Fritz</u>		(Month) (Day) (Year) <u>4/12/56</u> 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/25/88</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Matlock</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>--</u>	
17. INFORMANT AND ADDRESS <u>Mr. Wm. Murray 1229 Patapsco St.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
151X Immediate cause (a) <u>GASTRIC 1/2 MORRHUACE</u>			<u>1 week</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>CANCER of STOMACH</u>			<u>unknown</u>
(c) <u>Anemia secondary to b</u>			<u>unknown</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>mal nourished</u>			<u>unknown</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/12, 1956</u> , to <u>4/12, 1956</u> , that I last saw the deceased alive on <u>4/11, 1956</u> , and that death occurred at <u>2:25</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Cliff Campbell</u>		ADDRESS <u>4605 (drinks) ave</u>	
DATE SIGNED <u>9/13/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/16/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC. 715 Light St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
<div style="text-align: right;">03686</div> <div style="text-align: center;">3657</div> <div style="text-align: right;">Reg. Dist. No. 49</div>									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3488 McShane Way					d. STREET ADDRESS 3488 McShane Way				
3. NAME OF DECEASED (Type or print) First Middle Last Bernice T Froeman					4. DATE OF DEATH Month Day Year April 4 1956				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1911		9. AGE (In years last birthday) 44 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Hospital		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Schaefer					14. MOTHER'S MAIDEN NAME Carrie				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Address Leonard G. Froeman 3488 Mc Shane Way.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Paul F. Guerin</i> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Parkwood			22d. LOCATION (City, town, or county) (State) Parkville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.					24a. REC'D BY REGISTRAR APR 12 1956		24b. REGISTRAR'S SIGNATURE <i>Stan P. Kelly</i>		

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03687

3729

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS Baltimore County Home			
3. NAME OF DECEASED (Type or print) First John Middle A Last Fryfogles				4. DATE OF DEATH Month April Day 26 , Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 14-1871	9. AGE (In years last birthday) 85 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown FARMER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown John Fryfogles				14. MOTHER'S MAIDEN NAME Unknown MARGARET MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown No				16. SOCIAL SECURITY NO. NONE Unknown		17. INFORMANT Address Records Spring Grove State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Years Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Spring Grove State Hospital				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2-27- , 19 56 , to 4-26- , 19 56 , that I last saw the deceased alive on 4-26- , 19 56 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4-26-56							
ACTUAL SIGNATURE Stella Wachslers M.D.				PHYSICIAN'S NAME (Type) Stella Wachslers, M. D.			
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-28-56		22c. NAME OF CEMETERY OR CREMATORY Not at Catonsville	
22d. LOCATION (City, town or county) Catonsville				22e. (State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE Robt. C. & B. M. Walters				ADDRESS Pratt & Stricker		24a. REC'D BY REGISTRAR APR 30 1956	
24b. REGISTRAR'S SIGNATURE D. E. Harry							

BUREAU V. S.

APR 30 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03688

3730 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>Md</u> COUNTY <u>BALTIMORE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>606 COLERAINE RD</u>		LENGTH OF STAY (in this place) <u>5 yrs.</u>		STREET ADDRESS (If rural give location) <u>606 COLERAINE RD</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Michael Joseph Garaghty, Sr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 2, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JUNE 4, 1904</u>	
9. AGE last birthday <u>51</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Municipal</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Michael J. Garaghty</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. REILLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mary A. Garaghty 606 Coleraine Rd</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
50.5X IMMEDIATE CAUSE (A) <u>Pulmonary Fibrosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>DUE TO</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12.1.45</u>, 19....., to <u>4.2.56</u>, 19....., that I last saw the deceased alive on <u>4.2.56</u>, 19....., and that death occurred at <u>9:50</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Nathan Rasmussen</u>				ADDRESS (Street, city, town, state) <u>M.D. 206 S. Gilman St</u>			
DATE SIGNED <u>4.3.56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>April 5 1956</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) <u>BALTIMORE Md.</u>	
24. REC'D BY REGISTRAR <u>APR 5 1956</u>		REGISTRAR'S SIGNATURE <u>U. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwal</u>		ADDRESS <u>2101 Frederick Ave Balto. Md.</u>	

3250 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

03652

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEAREST RELATIVE

14. SIGNATURE OF CLERGYMAN

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF TOWN CLERK

21. SIGNATURE OF VILLAGE CLERK

22. SIGNATURE OF CITY CLERK

23. SIGNATURE OF STATE CLERK

24. SIGNATURE OF NATIONAL CLERK

25. SIGNATURE OF INTERNATIONAL CLERK

26. SIGNATURE OF UNITED NATIONS CLERK

27. SIGNATURE OF WORLD CLERK

28. SIGNATURE OF GALAXY CLERK

29. SIGNATURE OF UNIVERSE CLERK

30. SIGNATURE OF COSMOS CLERK

31. SIGNATURE OF OMNIBUS CLERK

32. SIGNATURE OF UNIVERSAL CLERK

33. SIGNATURE OF SUPREMACY CLERK

34. SIGNATURE OF SOVEREIGNTY CLERK

BUREAU V. S.

APR 5 1936

RECEIVED

BROUGHT HERE

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body, or by the registrar or other person who has been authorized by the State Department of Health to fill out this certificate. It is to be filled out in duplicate, one copy to be retained by the person who fills it out, and the other copy to be sent to the State Department of Health, Baltimore, Maryland.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03689

3731 CERTIFICATE OF DEATH

Reg. Dist. No. 44

Item #1 - File # 192-41256-mml.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		LENGTH OF STAY (in this place) <u>16 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		TOWN <u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carrolls Nurseing Home</u>				STREET ADDRESS (If rural give location) <u>14 Southship Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Joseph Thomas Gehr</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov, 2, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward Gehr</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Berry</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			16. SOCIAL SECURITY NO. <u>202-03-8058</u>		17. INFORMANT & ADDRESS <u>Mrs H. Benge Simmons, Perryville, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio-Vas. Dis - 10 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) <u>Senility & Mental Changes</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Self-imposed Starvation -</u>				2 mos -			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 20, 1956</u> , to <u>April 9, 1956</u> , that I last saw the deceased alive on <u>April 2, 1956</u> , and that death occurred at <u>9:57 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. B. Davis M.D.</u>				DATE SIGNED <u>April 9, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-12-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR DATE <u>4/12/56</u>		REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md.</u>			

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

1. Name of deceased (Print or type)

2. Date of death

3. Sex of deceased

4. Age of deceased

5. Race

6. Usual residence (Print or type)

7. Date of birth

8. Place of birth

9. Usual occupation (Print or type)

10. Date of death

11. Cause of death

12. Usual residence (Print or type)

13. Date of birth

14. Place of birth

15. Usual occupation (Print or type)

16. Date of death

17. Cause of death

18. Usual residence (Print or type)

19. Date of birth

20. Place of birth

21. Usual occupation (Print or type)

22. Date of death

23. Cause of death

24. Usual residence (Print or type)

25. Date of birth

26. Place of birth

27. Usual occupation (Print or type)

28. Date of death

29. Cause of death

30. Usual residence (Print or type)

31. Date of birth

32. Place of birth

33. Usual occupation (Print or type)

34. Date of death

35. Cause of death

36. Usual residence (Print or type)

37. Date of birth

38. Place of birth

39. Usual occupation (Print or type)

40. Date of death

41. Cause of death

42. Usual residence (Print or type)

43. Date of birth

44. Place of birth

45. Usual occupation (Print or type)

46. Date of death

47. Cause of death

48. Usual residence (Print or type)

49. Date of birth

50. Place of birth

51. Usual occupation (Print or type)

52. Date of death

53. Cause of death

54. Usual residence (Print or type)

55. Date of birth

56. Place of birth

57. Usual occupation (Print or type)

58. Date of death

59. Cause of death

60. Usual residence (Print or type)

61. Date of birth

62. Place of birth

63. Usual occupation (Print or type)

64. Date of death

65. Cause of death

66. Usual residence (Print or type)

67. Date of birth

68. Place of birth

69. Usual occupation (Print or type)

70. Date of death

71. Cause of death

72. Usual residence (Print or type)

73. Date of birth

74. Place of birth

75. Usual occupation (Print or type)

76. Date of death

77. Cause of death

78. Usual residence (Print or type)

79. Date of birth

80. Place of birth

81. Usual occupation (Print or type)

82. Date of death

83. Cause of death

84. Usual residence (Print or type)

85. Date of birth

86. Place of birth

87. Usual occupation (Print or type)

88. Date of death

89. Cause of death

90. Usual residence (Print or type)

91. Date of birth

92. Place of birth

93. Usual occupation (Print or type)

94. Date of death

95. Cause of death

96. Usual residence (Print or type)

97. Date of birth

98. Place of birth

99. Usual occupation (Print or type)

100. Date of death

101. Cause of death

102. Usual residence (Print or type)

103. Date of birth

104. Place of birth

105. Usual occupation (Print or type)

106. Date of death

107. Cause of death

108. Usual residence (Print or type)

109. Date of birth

110. Place of birth

111. Usual occupation (Print or type)

112. Date of death

113. Cause of death

IN WITNESS WHEREOF

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING. IT IS TO BE KEPT ON FILE IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS AFTER THE DATE OF DEATH.

BUREAU V. S.
APR 13 1956

RECEIVED

3732

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 37014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove Hospital		d. STREET ADDRESS 39 N. Potomac St.	
3. NAME OF DECEASED (Type or print) Katherine Geisendorfer		4. DATE OF DEATH 4-20-56 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bach		14. MOTHER'S MAIDEN NAME Margare Mierling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Joseph White		Address 35 N. Potomac St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-12-53 19, to 4-20-56 , that I last saw the deceased alive on 4-20-56 , 19, and that death occurred at 11:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Daniel Edwards MD		M.D. Spring Grove Hospital 4-20-56	
PHYSICIAN'S NAME (Type) DAVID EDWARDS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 24, 1956	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		ADDRESS 3000 E. Baltimore St.	
DATE APR 24 1956		24b. REGISTRAR'S SIGNATURE V. E. Henry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
John Doe		April 24, 1956	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTH DATE		BIRTH PLACE	
April 15, 1891		Maryland	
MANNER OF DEATH		CAUSE OF DEATH	
Natural		Heart Disease	
DISEASE OR INJURY		PLACE OF DEATH	
Myocardial Infarction		Home	
DATE OF REPORT		REPORTED BY	
April 24, 1956		John Doe	

BUREAU V. S.

APR 24 1956

RECEIVED

FILED	APR 24 1956	DEPT. OF HEALTH
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3733

CERTIFICATE OF DEATH

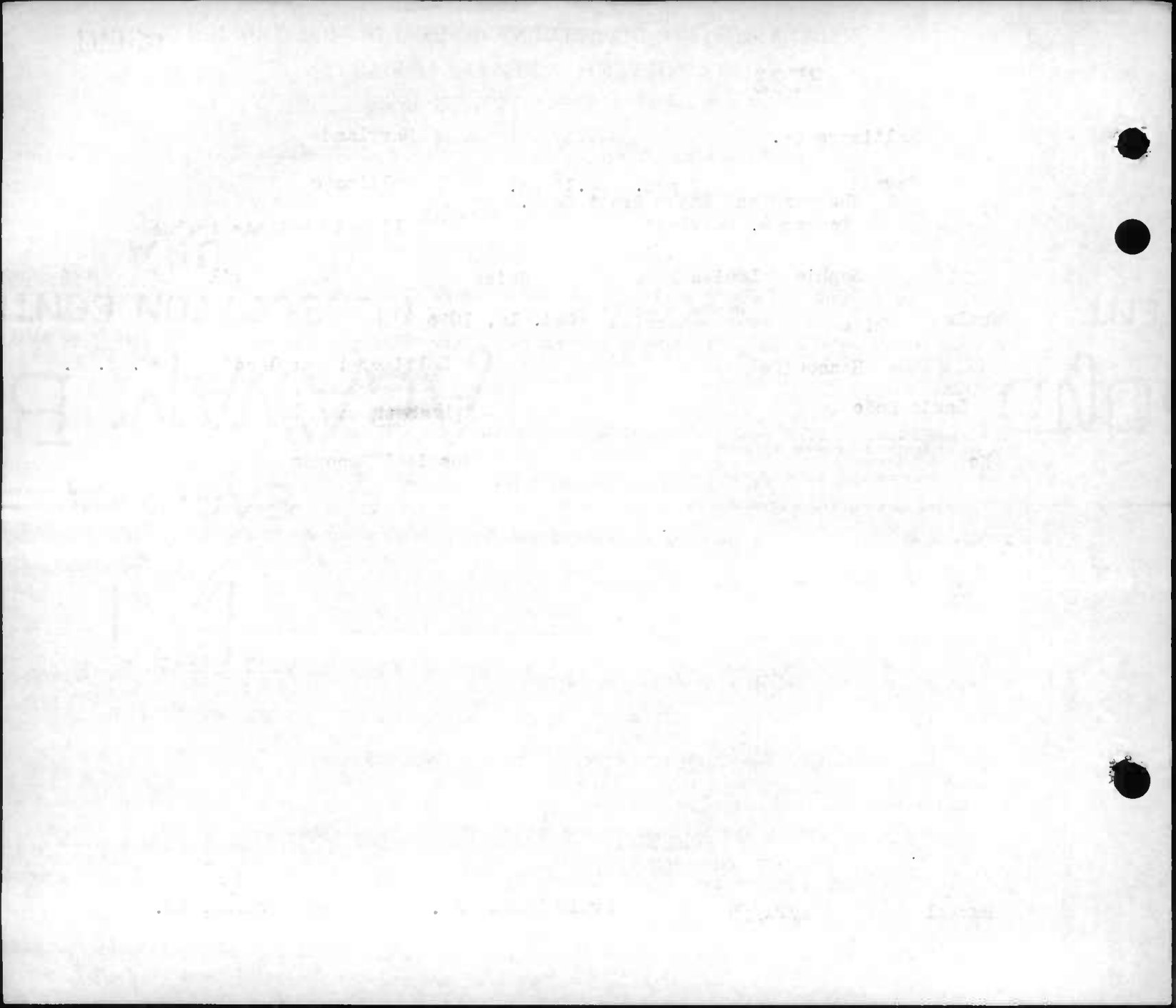
Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore Co.		MARYLAND		STATE Maryland		COUNTY ✓	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson		LENGTH OF STAY (in this place) 3 yrs. 2 mo. 19 da.		CITY (If outside corporate limits, write RURAL OR and give nearest town) Baltimore		3001.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard and Enoch Pratt Hosp. Towson 4, Maryland				STREET ADDRESS 4303 Liberty Heights Avenue		(If rural give location)	
3. NAME OF DECEASED: (Type or Print) Sophie Louise Bode Geisz				4. DATE OF DEATH: April 18 1956			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Oct. 16, 1870	
				9. AGE last birthday: 85 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: Housewife				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
13. FATHER'S NAME: Louis Bode				14. MOTHER'S MAIDEN NAME: Elizabeth unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Hospital Records	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Broncho pneumonia				Term	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				5 yr +	
DUE TO (b) Chronic myocarditis				"	
DUE TO (c) Generalized arteriosclerosis				"	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis				"	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 29, 1953 , to Apr 18, 1956 , that I last saw the deceased alive on Apr 17, 1956 , and that death occurred at 8:45 PM from the causes and on the date stated above.					
SIGNATURE W. Elgin, M.D.		THE SHEPPARD & ENOCH PRATT HOSPITAL		ADDRESS Towson 4 Md. 4/19/56	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF 4/21/56		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
DATE REC'D BY LOCAL REGISTRAR April 20, 1956		REGISTRAR'S SIGNATURE U. W. Hedrick, M.D.		24. FUNERAL DIRECTOR J. Pickner & Sons - Balt. Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03602

3734

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Calverville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 SPRING GROVE STATE HOSP.				d. STREET ADDRESS 1400 HOLLINS ST			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ROBERT K. GEMMILL				4. DATE OF DEATH Month APRIL Day 28 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1869		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saw-mill operator		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.		11. BIRTHPLACE (State or foreign country) U. S. A. (state not known)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME not known				14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Frances Gemmill, 417 Whitridge Ave #18			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from AUG. 25, 1955 to APR. 28, 1956 , that I last saw the deceased alive on APR. 28, 1956 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Jewene E. Shapiro M.D.				Spring Grove State Hospital 4/28/1956			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Marford Road #14				24a. REC'D BY REGISTRAR DATE 5/2/56		24b. REGISTRAR'S SIGNATURE T. E. Harry	

CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM J. HARRIS		2. SEX M		3. AGE 68	
4. DATE OF DEATH APR 10 1956		5. TIME OF DEATH 10:00 A.M.		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN W. J. HARRIS	
10. SIGNATURE OF REGISTRAR W. J. HARRIS		11. SIGNATURE OF WITNESS W. J. HARRIS		12. SIGNATURE OF WITNESS W. J. HARRIS	
13. SIGNATURE OF WITNESS W. J. HARRIS		14. SIGNATURE OF WITNESS W. J. HARRIS		15. SIGNATURE OF WITNESS W. J. HARRIS	
16. SIGNATURE OF WITNESS W. J. HARRIS		17. SIGNATURE OF WITNESS W. J. HARRIS		18. SIGNATURE OF WITNESS W. J. HARRIS	
19. SIGNATURE OF WITNESS W. J. HARRIS		20. SIGNATURE OF WITNESS W. J. HARRIS		21. SIGNATURE OF WITNESS W. J. HARRIS	
22. SIGNATURE OF WITNESS W. J. HARRIS		23. SIGNATURE OF WITNESS W. J. HARRIS		24. SIGNATURE OF WITNESS W. J. HARRIS	
25. SIGNATURE OF WITNESS W. J. HARRIS		26. SIGNATURE OF WITNESS W. J. HARRIS		27. SIGNATURE OF WITNESS W. J. HARRIS	
28. SIGNATURE OF WITNESS W. J. HARRIS		29. SIGNATURE OF WITNESS W. J. HARRIS		30. SIGNATURE OF WITNESS W. J. HARRIS	
31. SIGNATURE OF WITNESS W. J. HARRIS		32. SIGNATURE OF WITNESS W. J. HARRIS		33. SIGNATURE OF WITNESS W. J. HARRIS	
34. SIGNATURE OF WITNESS W. J. HARRIS		35. SIGNATURE OF WITNESS W. J. HARRIS		36. SIGNATURE OF WITNESS W. J. HARRIS	
37. SIGNATURE OF WITNESS W. J. HARRIS		38. SIGNATURE OF WITNESS W. J. HARRIS		39. SIGNATURE OF WITNESS W. J. HARRIS	
40. SIGNATURE OF WITNESS W. J. HARRIS		41. SIGNATURE OF WITNESS W. J. HARRIS		42. SIGNATURE OF WITNESS W. J. HARRIS	
43. SIGNATURE OF WITNESS W. J. HARRIS		44. SIGNATURE OF WITNESS W. J. HARRIS		45. SIGNATURE OF WITNESS W. J. HARRIS	
46. SIGNATURE OF WITNESS W. J. HARRIS		47. SIGNATURE OF WITNESS W. J. HARRIS		48. SIGNATURE OF WITNESS W. J. HARRIS	
49. SIGNATURE OF WITNESS W. J. HARRIS		50. SIGNATURE OF WITNESS W. J. HARRIS		51. SIGNATURE OF WITNESS W. J. HARRIS	
52. SIGNATURE OF WITNESS W. J. HARRIS		53. SIGNATURE OF WITNESS W. J. HARRIS		54. SIGNATURE OF WITNESS W. J. HARRIS	
55. SIGNATURE OF WITNESS W. J. HARRIS		56. SIGNATURE OF WITNESS W. J. HARRIS		57. SIGNATURE OF WITNESS W. J. HARRIS	
58. SIGNATURE OF WITNESS W. J. HARRIS		59. SIGNATURE OF WITNESS W. J. HARRIS		60. SIGNATURE OF WITNESS W. J. HARRIS	
61. SIGNATURE OF WITNESS W. J. HARRIS		62. SIGNATURE OF WITNESS W. J. HARRIS		63. SIGNATURE OF WITNESS W. J. HARRIS	
64. SIGNATURE OF WITNESS W. J. HARRIS		65. SIGNATURE OF WITNESS W. J. HARRIS		66. SIGNATURE OF WITNESS W. J. HARRIS	
67. SIGNATURE OF WITNESS W. J. HARRIS		68. SIGNATURE OF WITNESS W. J. HARRIS		69. SIGNATURE OF WITNESS W. J. HARRIS	
70. SIGNATURE OF WITNESS W. J. HARRIS		71. SIGNATURE OF WITNESS W. J. HARRIS		72. SIGNATURE OF WITNESS W. J. HARRIS	
73. SIGNATURE OF WITNESS W. J. HARRIS		74. SIGNATURE OF WITNESS W. J. HARRIS		75. SIGNATURE OF WITNESS W. J. HARRIS	
76. SIGNATURE OF WITNESS W. J. HARRIS		77. SIGNATURE OF WITNESS W. J. HARRIS		78. SIGNATURE OF WITNESS W. J. HARRIS	
79. SIGNATURE OF WITNESS W. J. HARRIS		80. SIGNATURE OF WITNESS W. J. HARRIS		81. SIGNATURE OF WITNESS W. J. HARRIS	
82. SIGNATURE OF WITNESS W. J. HARRIS		83. SIGNATURE OF WITNESS W. J. HARRIS		84. SIGNATURE OF WITNESS W. J. HARRIS	
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88. SIGNATURE OF WITNESS W. J. HARRIS		89. SIGNATURE OF WITNESS W. J. HARRIS		90. SIGNATURE OF WITNESS W. J. HARRIS	
91. SIGNATURE OF WITNESS W. J. HARRIS		92. SIGNATURE OF WITNESS W. J. HARRIS		93. SIGNATURE OF WITNESS W. J. HARRIS	
94. SIGNATURE OF WITNESS W. J. HARRIS		95. SIGNATURE OF WITNESS W. J. HARRIS		96. SIGNATURE OF WITNESS W. J. HARRIS	
97. SIGNATURE OF WITNESS W. J. HARRIS		98. SIGNATURE OF WITNESS W. J. HARRIS		99. SIGNATURE OF WITNESS W. J. HARRIS	
100. SIGNATURE OF WITNESS W. J. HARRIS		101. SIGNATURE OF WITNESS W. J. HARRIS		102. SIGNATURE OF WITNESS W. J. HARRIS	

RECEIVED
MAY 2 1956
BUREAU V. 3

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3735 CERTIFICATE OF DEATH

03693

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk - 22, Md.</u>		53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>				STREET ADDRESS (If rural give location) <u>7502 Parson Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u>		(Middle) <u>BEYER</u>		(Last) <u>GREEK</u>		(Month) (Day) (Year) <u>Apr. 5, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Mar. 30, 1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Beyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>George Greek 7502 Parson Ave. Balto. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
150X IMMEDIATE CAUSE (A) <u>Metastatic Ca of lungs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>62 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ca of esophagus</u>						<u>831</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-3</u> , 19 <u>56</u> , to <u>4-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>56</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wilmer H. Gallagher</u>				ADDRESS (Street, city, town, state) <u>M.D. 6207 Frederick Ave. Balt. 22, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/9/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>APR 12 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wilrich Funeral Home</u>		ADDRESS <u>Dundalk, Md.</u>	

CERTIFICATE OF DEATH

For Use by

AT THE RESIDENCE OF THE DECEASED

AT THE PLACE OF DEATH

COUNTY OF <u>ALLEGANY</u> CITY OF <u>UNION</u> TOWNSHIP OF <u>UNION</u>		MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS	
NAME OF DECEASED <u>JOHN A. PIERCE</u>		SEX <u>MALE</u>	
DATE OF BIRTH <u>NOV 10 1892</u>		PLACE OF BIRTH <u>UNION, ALLEGANY CO., MD.</u>	
DATE OF DEATH <u>APR 12 1956</u>		PLACE OF DEATH <u>UNION, ALLEGANY CO., MD.</u>	
CAUSE OF DEATH <u>HEART DISEASE</u>		MANNER OF DEATH <u>NATURAL</u>	
SIGNATURE OF PHYSICIAN <u>JOHN A. PIERCE</u>		SIGNATURE OF DECEASED <u>JOHN A. PIERCE</u>	

SIGNATURE OF WITNESS <u>JOHN A. PIERCE</u>		SIGNATURE OF DECEASED <u>JOHN A. PIERCE</u>	
SIGNATURE OF PHYSICIAN <u>JOHN A. PIERCE</u>		SIGNATURE OF DECEASED <u>JOHN A. PIERCE</u>	
SIGNATURE OF PHYSICIAN <u>JOHN A. PIERCE</u>		SIGNATURE OF DECEASED <u>JOHN A. PIERCE</u>	
SIGNATURE OF PHYSICIAN <u>JOHN A. PIERCE</u>		SIGNATURE OF DECEASED <u>JOHN A. PIERCE</u>	
SIGNATURE OF PHYSICIAN <u>JOHN A. PIERCE</u>		SIGNATURE OF DECEASED <u>JOHN A. PIERCE</u>	

BUREAU V. S.

APR 12 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE IS DEEMED TO HAVE BEEN DECEASED ON THE DATE AND AT THE PLACE INDICATED. THIS CERTIFICATE IS VALID FOR ALL PURPOSES. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE IS DEEMED TO HAVE BEEN DECEASED ON THE DATE AND AT THE PLACE INDICATED. THIS CERTIFICATE IS VALID FOR ALL PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03694

3736

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New Jersey</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Quinn's Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>East Orange</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.F. D #2 Lyons Mills Rd.</u>		STREET ADDRESS (If rural, give location) <u>31 Franklin St</u>	
3. NAME OF DECEASED (Type or Print) <u>Ellen Dunsmore Griffith</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>April 5</u> 19 <u>56</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 2, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
13. FATHER'S NAME <u>Charles E. Utermohle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Deohan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Beesye M. Weidman (Quinn's Mills)</u>		18. MEDICAL CERTIFICATION <u>R.F. D #2 Lyons Mills Rd</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION
Immediate cause (a) <u>UREMIA (KIDNEY FAILURE)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS.</u>
Antecedent cause(s) (b) <u>METASTATIC CARCINOMA</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>CERVICAL CARCINOMA</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1955, to April, 1956, that I last saw the deceased alive on 4-5, 1956, and that death occurred at 3:00 P.m., from the causes and on the date stated above.

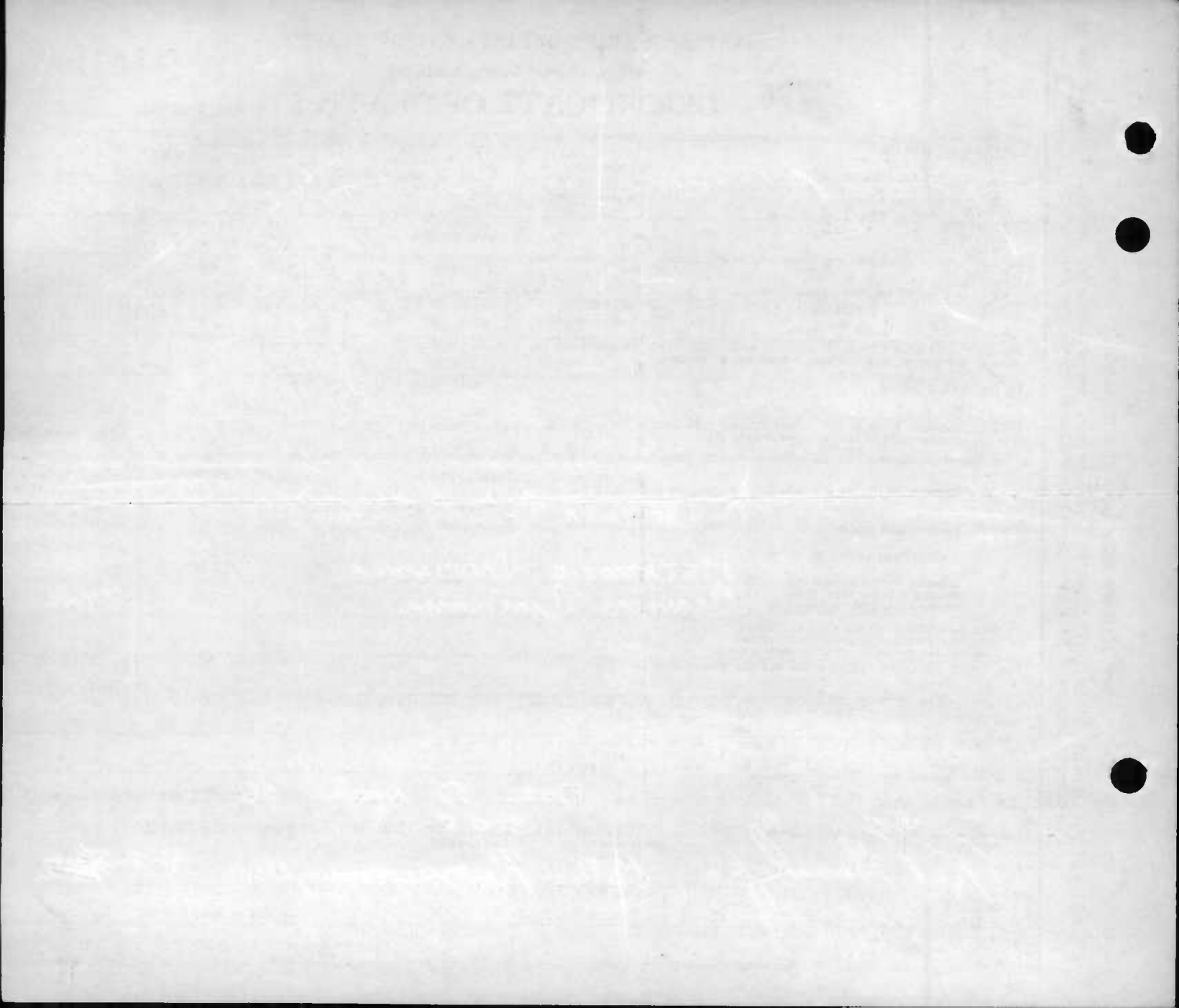
SIGNATURE A. V. Houck Jr. (Degree or title) M.D. ADDRESS RANDALLSTOWN, MD. DATE SIGNED 4-5-56

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4-7-56</u>	<u>Woodlawn Cemetery</u>	<u>Woodlawn, Baltimore Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 7th 1956</u>	<u>R.W.</u>	<u>George J. Ruth Inc</u>	<u>1735 Hanford Ave</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03695

31

3737 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Woodlawn</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5814 Gwynn Oak Ave.</u>				STREET ADDRESS (If rural give location) <u>5814 Gwynn Oak Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>LETTIA</u> (First) <u>GRISWOLD</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 23.</u> <u>19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 4, 1865</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Moore</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Ritter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Miss Lillian Griswold-5814 Gwynn Oak Av</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
904.0 IMMEDIATE CAUSE (A) <u>Suicidality 17 age</u>				CERTIFICATION APPROVED CHIEF OR ASST. MEDICAL EXAMINER <u>[Signature]</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Fractured hip</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.) <u>home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>5814 Gwynn Oak Ave. Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Before death</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>slipped & fell to floor</u>			
22. I hereby certify that I attended the deceased from <u>March 19 56</u> , to <u>April 23 19 56</u> , that I last saw the deceased alive on <u>4-23</u> , 19 <u>56</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. J. Abbot</u>		M.D. <u>4509 Liberty Hwy Wt. Ave</u>		ADDRESS (Street, city, town, state) <u>Pikesville, Md.</u>		DATE SIGNED <u>4-24-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
24. REC'D BY REGISTRAR <u>APR 25 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Trebner & Sons</u>		ADDRESS <u>Balto 17th</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

State of Maryland

County of _____

Name of Deceased _____

Sex _____ Age _____

Married _____ Single _____

Occupation _____

Place of Birth _____

Date of Birth _____

Place of Death _____

Time of Death _____

Cause of Death _____

Immediate Cause of Death _____

Underlying Cause of Death _____

Contributing Cause of Death _____

Period of Incubation _____

Time of Onset of Illness _____

Time of Death _____

Time of Death _____

Time of Death _____

Time of Death _____

Time of Death _____

Time of Death _____

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BUREAU V. S.

APR 26 1956

RECEIVED

MEDICAL CERTIFICATION

VS A1S (4)
ISM 9/SS

3739

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 TOWN Rural: Towson	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN Towson, Md.	55
HOSPITAL OR INSTITUTION OR STREET ADDRESS 01 Eudowood Sanatorium Towson 4, Maryland		STREET ADDRESS (If rural give location) 610 Delaware Ave.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) John	(Middle) Russell	(Last) Hall	(Month) 4 - (Day) 23 - (Year) 1956
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: 4-30-74
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Wireman		10b. KIND OF BUSINESS OR INDUSTRY: Edison Co.	
13. FATHER'S NAME: William Hall		11. BIRTHPLACE (State or foreign country): Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): No		16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: Personal History	
18. MEDICAL CERTIFICATION		12. CITIZEN OF WHAT COUNTRY: U.S.	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
002X Immediate cause (a) Pulmonary Tuberculosis.		15 years	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) DUE TO (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		20. AUTOPSY?	
SUICIDE HOMICIDE		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 5-2, 1942, to 4-23, 1956, that I last saw the deceased alive on 4-22, 1956, and that death occurred at 6:20 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Kline M.D. Eudowood Sanatorium - Towson 4, Maryland

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	April 25, 1956	PROSPECT HILL CEM.	TOWSON, MD.	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. UNITAL DIRECTOR	ADDRESS	
April 24, 1956	Mabel C. Gray	John Burne' Bone	Towson, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 25 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3740

CERTIFICATE OF DEATH

03698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>371 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>Route #2 Box 192</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN W. HALL</u>				4. DATE OF DEATH Month Day Year <u>April 17 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 22, 1890</u>		9. AGE (In years last birthday) yrs. <u>65</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Supper Club</u>		11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Frank Hall</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth - MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>219-32-0718</u>		17. INFORMANT Address <u>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR. PULMONALE</u> <u>241X</u> DUE TO <u>PULMONARY EMPHYSEMA AND ASTHMATIC BRONCHITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS, OLD MYOCARDIAL INFARCTION, 3. ARTERIOSCLEROTIC HEART DISEASE.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>55</u> , to <u>April 17</u> , 19 <u>56</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Francis G. Dickey</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u> <u>4/18/56</u>							
ACTUAL SIGNATURE <u>Francis G. Dickey</u>							
PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY, M.D., Chief, Medical Service, VAH, FT. HOWARD, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard C. Fleming</u>				24a. REC'D BY REGISTRAR <u>April 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

CERTIFICATE OF DEATH

3100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 28 1956

RECEIVED

4-28-56

MARYLAND STATE DEPARTMENT OF HEALTH

03699

2411 N. Charles Street, Baltimore

3741 CERTIFICATE OF DEATH

Reg. Dist. No. 30

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Catoonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>		STREET ADDRESS (If rural, give location) <u>-----</u>	
3. NAME OF DECEASED (Type or Print) <u>Sarah</u> (First) <u>Ada</u> (Middle) <u>Harrison</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>29</u> (Day) <u>1956</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16, 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Downey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Samuel J. Harrison Rock Hall, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422-1 Immediate cause (a) <u>Cerebral thrombosis, multiple</u>		1 month
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic cardiovascular disease</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 7, 1956, to April 29, 1956, that I last saw the deceased alive on April 28, 1956, and that death occurred at 9:35 a.m., from the causes and on the date stated above.

SIGNATURE <u>Herbert L. Leitch, M.D.</u>	(Degree or title)	ADDRESS <u>5305 East Drive Baltimore-27, Md.</u>	DATE SIGNED <u>4/29/56</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 29, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>W. Coley Chapel</u>	LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>
DATE REC'D BY LOCAL REG. <u>4/29/56</u>	REGISTRAR'S SIGNATURE <u>V. E. Harrison</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	ADDRESS <u>Church Hall</u>

MARGIN RESERVED FOR BINDING

VS. A15

BUREAU V. S.

MAY 2 1956

RECEIVED

3742

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/SS

1900 Eutaw Place

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS		TREATMENT		HISTORICAL		PATHOLOGICAL		LABORATORY		POST-MORTEM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	

BUREAU V. S.

APR 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3743 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03702

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harewood Park			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest 16wn) Chase			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harewood Park, P.R.R. Crossing				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First Ford Middle Ray Last Helmick, Jr.				4. DATE OF DEATH Month April Day 16 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1944		9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months 12 Days 16 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Webster Springs, W.Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ford Ray Helmick, Sr.				14. MOTHER'S MAIDEN NAME Ora Dye			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Ford Ray Helmick, Sr.		Address Chase 20, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture of skull 802x DUE TO Conditions, if any, which gave rise to immediate cause (b) Fractures of all bones of body (c) --- DUE TO (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by P.R.R. train					
20c. TIME OF INJURY Month, Day, Year 5:15 p. m. April 16 1956		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Harewood Grocery Store, Chase		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/17/56	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-56		22c. NAME OF CEMETERY OR CREMATORY Belair Memorial Garden		22d. LOCATION (City, town, or county) (State) Belair, Maryland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly		ADDRESS Essey, Md.		24a. REC'D BY REGISTRAR APR 18 1956		24b. REGISTRAR'S SIGNATURE Mrs. Edith Hurley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03703

3744

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Shady Nook, Rolling Rd.</u>		d. STREET ADDRESS <u>714 McHenry St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>P.</u> Last <u>Henkel</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1883</u>
9. AGE (In years, last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Glass Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henkel</u>		14. MOTHER'S MAIDEN NAME <u>Bridget O'Holleran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-07-2439</u>	
17. INFORMANT <u>J. Norman Henkel</u>		Address <u>701 Charing Cross Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE -</u> DUE TO <u>PULMONARY EDEMA -</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>PNEUMONITIS - PULMONARY EMPHYSEMA</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/1</u> , 19 <u>56</u> , to <u>4/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>56</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5800 Edmondson Ave. Balto. Md.</u> DATE SIGNED <u>4/17/56</u>			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 19/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>		24a. REC'D BY REGISTRAR <u>4101 Edmondson Ave</u> 24b. REGISTRAR'S SIGNATURE <u>P. E. Harris</u>	

CERTIFICATE OF DEATH

BUREAU V. 3

APR 18 1956

RECEIVED

DEPARTMENT OF HEALTH - BALTIMORE 18 3754	
NAME OF DECEASED [Faint text]	
SEX [Faint text]	
AGE [Faint text]	
DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]	
CAUSE OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]	
SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF JURY [Faint text]	
SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]	
SIGNATURE OF [Faint text] [Faint text]	

1 Page 4 Page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/55

3745

CERTIFICATE OF DEATH

03705

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 130 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle E. Last HESS				4. DATE OF DEATH Month April Day 21 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/19/83	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles W. Creek				14. MOTHER'S MAIDEN NAME Sarah Mallott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. None			
17. INFORMANT Clin. Rec. Vets. Adm. Fort Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM WITH GENERALIZED METASTASIS 1541 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that VA attended the deceased from December 13, 1955 , to April 21, 1956 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Mark				M.D. VAH, Fort Howard, Md.			
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Tickner & Sons, Inc., North Ave., Baltimore, Md.				24a. REC'D BY REGISTRAR APR 25 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Farker	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Lena Howard		Female		30 days				Baltimore	
Name of Physician		Name of Hospital		Name of Doctor		Name of Nurse		Name of Attending Physician	
J. J. Howard		J. J. Howard		J. J. Howard		J. J. Howard		J. J. Howard	
Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death	
Heart Failure		Natural		Home		April 24, 1956		10:00 AM	
Signature of Physician		Signature of Hospital		Signature of Doctor		Signature of Nurse		Signature of Attending Physician	
J. J. Howard		J. J. Howard		J. J. Howard		J. J. Howard		J. J. Howard	

BUREAU V. S.

APR 24 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3746

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>90 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>5122 Franklinton Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS C. HESSLER</u>				4. DATE OF DEATH Month Day Year <u>April 6 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 20, 1886</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Jacob Hessler</u>				14. MOTHER'S MAIDEN NAME <u>Annie LaRoach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>215-09-1170</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE COMMON BILE DUCT WITH METASTASIS</u> DUE TO <u>TO THE LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>155X</u> (c) <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 7, 1956</u> , to <u>April 6, 1956</u> , that he died on <u>April 6, 1956</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH Ft. Howard, Maryland</u> DATE SIGNED <u>4/6/56</u> ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. <u>VAH Ft. Howard, Maryland</u> PHYSICIAN'S NAME (Type) <u>DONALD D. MARK</u> <u>VAH Ft. Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Road, Balto. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 9 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

MEDICAL CERTIFICATION

2

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X

M

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
CERTIFICATE NO.		REGISTERED		FILED		INDEXED		SERIALIZED		RECEIVED		DATE		TIME	
SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGY		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		CITY OF REGISTRATION		STATE OF REGISTRATION		COUNTRY OF REGISTRATION		CAUSE OF REGISTRATION		MANNER OF REGISTRATION	
REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS	

BUREAU V. S.

APR 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY BALTIMORE MARYLAND CITY OR TOWN CATONSVILLE LENGTH OF STAY (in this place) 1 yr HOSPITAL OR INSTITUTION OR STREET ADDRESS RIDGEWAY MANOR				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD COUNTY BALTIMORE CITY OR TOWN BALTIMORE STREET ADDRESS 2210 CALLOWAY AVE.			
3. NAME OF DECEASED (Type or Print) ISIAH HEYMAN				4. DATE OF DEATH (Month) 4 (Day) 27 (Year) 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, WIDOWED	8. DATE OF BIRTH	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY GROCEER		11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME YEHESKAH				14. MOTHER'S MAIDEN NAME NAHAMA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS ISER HEYMAN - SAME			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cerebrovascular Accident ANTECEDENT CAUSE(S) DUE TO Generalized Arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 week 2 yrs			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1955 , to April 27, 1956 , that I last saw the deceased alive on April 26, 1956 , and that death occurred at 3:25 PM , from the causes and on the date stated above.							
SIGNATURE John M. Kay				ADDRESS (Street, city, town, state) 6014 Edmonson Ave Catonsville Md. DATE SIGNED 5/2/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-29-56		NAME OF CEMETERY OR CREMATORY Mt Carmel		LOCATION (City, town, or county) Balto Md	
24. REC'D BY REGISTRAR MAY 1 1956		REGISTRAR'S SIGNATURE E. Harry		25. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Entaw Pl	

CERTIFICATE OF DEATH

Form No. 1

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35	SEX M	RACE W	DATE OF BIRTH 12-27-20
PLACE OF BIRTH MEMPHIS, TENN.		DATE OF DEATH 4-4-68			
PLACE OF DEATH MEMPHIS, TENN.		CAUSE OF DEATH SHOOTING			
MANNER OF DEATH SUICIDE		DISEASE OR INJURY GUNSHOT WOUND			
OCCUPATION ATTORNEY		EDUCATION HIGH SCHOOL			
RELIGION METHODIST		MARITAL STATUS MARRIED			
SPOUSE'S NAME JANE E. RAY		SPOUSE'S ADDRESS 1000 ...			
DECEASED'S ADDRESS 1000 ...		DECEASED'S CITY MEMPHIS			
DECEASED'S STATE TENN.		DECEASED'S ZIP 38102			
DECEASED'S COUNTRY USA		DECEASED'S COUNTY SHELBY			
DECEASED'S DISTRICT ...		DECEASED'S WARD ...			
DECEASED'S BLOCK ...		DECEASED'S LOT ...			
DECEASED'S TRACT ...		DECEASED'S SUBDIVISION ...			
DECEASED'S SECTION ...		DECEASED'S TOWNSHIP ...			
DECEASED'S RANGE ...		DECEASED'S COUNTY ...			
DECEASED'S STATE ...		DECEASED'S COUNTRY ...			

BUREAU V. 3

MAY 1 1968

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 0370831

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GWYN OAK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO MD	
c. LENGTH OF STAY IN b. 11 YRS		d. STREET ADDRESS 605 E 33rd ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AUGSBURG HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD First HOFFMAN Middle HOFFMAN Last		4. DATE OF DEATH 4/7/56 Month 4 Day 7 Year 1956	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1873 9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) GERMANY
13. FATHER'S NAME JOHN HOFFMAN		14. MOTHER'S MAIDEN NAME AMELIA CARMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. RECORDED AUGSBURG HOME	
17. INFORMANT RECORDED AUGSBURG HOME		Address CAMPFIELD RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Chronic Infections Arthritis DUE TO -8 yrs- (c) -Generalized Arterio-Sclerosis DUE TO -5 yrs-			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 31, 1950 , to April 7, 1956 , that I last saw the deceased alive on April 5, 1956 , and that death occurred at 4:25 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers M.D.		ADDRESS (Street, city or town, state) 4108 Liberty St Baltimore MD	
PHYSICIAN'S NAME (Type) Earl L. Chambers M. D.		DATE SIGNED 4-7-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/9/56	22c. NAME OF CEMETERY OR CREMATORY 1st United Co. Cem	22d. LOCATION (City, town, or county) (State) BALTO MD
23. FUNERAL DIRECTOR'S SIGNATURE Paul G. Reumann		ADDRESS 6067 Hayford Rd	24a. REC'D BY REGISTRAR APR 11 1956
			24b. REGISTRAR'S SIGNATURE Dr. H. E. Martin

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1956

RECEIVED

3658

CERTIFICATE OF DEATH

03709

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4402 Alan Drive		d. STREET ADDRESS 4402 Alan Drive	
3. NAME OF DECEASED (Type or print) Bella Hooper		4. DATE OF DEATH Month Apr. Day 16 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1886
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sect		10b. KIND OF BUSINESS OR INDUSTRY U.S. Steel Co.	
11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Judson V. Hooper		14. MOTHER'S MAIDEN NAME Mary B. Blair	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Juddie H. Layman		Address 4402 Alan Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 481X DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Snipple (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 minutes 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/26 , 19 54 , to 4/16 , 19 56 , that I last saw the deceased alive on 4/16 , 19 56 , and that death occurred at 2 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Reiter		ADDRESS (Street, city or town, state) 3408 Windsor Ave	
PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.		DATE SIGNED 4/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-20-56	22c. NAME OF CEMETERY OR CREMATORY Fairview	22d. LOCATION (City, town, or county) (State) Roanoke, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR APR 16 1956	
ADDRESS 4107 Wilkens Ave		24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Hiffer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1890		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1915		BALTIMORE		BALTIMORE		MARYLAND		1955		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY		POLITICAL PARTY		MILITARY SERVICE	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		METHODIST		NONE		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		COUNTRY OF BURIAL	
1955		BALTIMORE		BALTIMORE		MARYLAND		1955		BALTIMORE		BALTIMORE		MARYLAND	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

BUREAU V. S.

APR 18 1956

RECEIVED

3749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>172 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>50 Veterans Administration Hospital</u>				d. STREET ADDRESS <u>3650 Malden Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>D.</u> Last <u>HUBBS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 24, 1917</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Floor Covering</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Hubbs</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Begerly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW II 217-09-1309</u>		17. INFORMANT Address <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LIP WITH METASTASIS</u> <u>140X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GASTRIC ULCER, BLEEDING</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that K attended the deceased from <u>November 5, 1955</u> to <u>April 25, 1956</u> and that death occurred at <u>8:30 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>VAH, FORT HOWARD, MARYLAND</u> <u>4/2/56</u>							
ACTUAL SIGNATURE _____ M.D. <u>VAH, FORT HOWARD, MARYLAND</u>							
PHYSICIAN'S NAME (Type) <u>JOSEPH M. MILLER, M.D. Chief, Surgical Service VAH, FORT HOWARD, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u> <u>Wm Cook-Blight, Inc, 6009 Harford Rd., Balto. 11, Md</u>				24a. REC'D BY REGISTRAR <u>MAY 7 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Laffer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3750

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		DISEASE OR INJURY		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		RELIGION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CEMETERY		SIGNATURE OF INTERMENT		SIGNATURE OF CREMATION		SIGNATURE OF OTHER	

BUREAU Y. 3

MAY 7 1956

RECEIVED

CHESTERMAN BOARD

3750

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore Co.</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Balto.</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> 2 yr. 8 mo. 20 da.			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sheppard & Enoch Pratt Hosp., Towson 4, Md.</u>			STREET ADDRESS (If rural give location) <u>Wiseberg, Ba Co Maryland</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Maurice</u> <u>Hunter</u>			4. DATE OF DEATH: 4 21 1956		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Apr. 21, 1882</u>		
			9. AGE last birthday: 74 yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>signal operator</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Railroad</u>		
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Silas W. Hunter</u>			14. MOTHER'S MAIDEN NAME: <u>Sarah Henderson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY No.: <u>Hospital Records</u>		
17. INFORMANT & ADDRESS:					

18. MEDICAL CERTIFICATION			Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 Immediate cause (a) <u>Bronchopneumonia</u>			<u>Term.</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Chronic myocarditis</u>			<u>4 yr +</u>
(c) <u>Generalized arteriosclerosis</u>			<u>4 yr +</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Brain Syndrome due to Cerebral arteriosclerosis</u>			<u>4 yr +</u>
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from July 11, 1953 to April 21, 1956 that I last saw the deceased alive on April 20, 1956 and that death occurred at 8:15 A.M. from the causes and on the date stated above.

SIGNATURE <u>M. Elgin MD</u>		DATE SIGNED <u>4/21/56</u>	
THE SHEPPARD & ENOCH PRATT HOSPITAL		Towson, Md	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Apr. 24, 1956</u>	<u>Evon. Lutheran cem.</u>	<u>Shrewsbury, Pa.</u>
DATE REC'D BY LOCAL REGISTRAR		FUNERAL DIRECTOR	
<u>April 24, 1956</u>		<u>Mabel C. Gray</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>John Burnie Lowe, Towson, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 25 1956

RECEIVED

Reg. Dist. No.

3751

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville c. LENGTH OF STAY IN lb 19 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Caton Ridge Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First Irwin Middle Iglehart Last April 3, </div> 4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month April 3, Day 19 Year 56 </div>		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Unknown 9. AGE (In years last birthday) 73? yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown 10b. KIND OF BUSINESS OR INDUSTRY Unknown 11. BIRTHPLACE (State or foreign country) Unknown 12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Records Spring Grove State Hospital		14. MOTHER'S MAIDEN NAME Unknown 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right pubis at junction of horizontal ramus and descending ramus and fracture of rt. ischium Unknown -- Found on admission to hospital 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE REMAINS AND INJURIES Unknown -- Found on admission to hospital 20c. TIME OF INJURY Month, Day, Year Hour a. m. Unknown 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown 20f. (City or town) Unknown (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE <i>Geo S. M. Kieffer</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) George S. M. Kieffer, M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-2-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 4/5/56 22c. NAME OF CEMETERY OR CREMATORY Chin. of Med. Hsp. School Baltimore, Md. 22d. LOCATION (City, town, or county) Baltimore, Md. (State)		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR DATE APR 24 1956 24b. REGISTRAR'S SIGNATURE <i>V. E. Harry</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35 Years		April 15, 1956	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Teacher		High School		Hypertension		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3669

CERTIFICATE OF DEATH

Reg. Dist. No.

03713

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haithorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haithorpe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4511 Rehmann Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1866</u>
9. AGE (In years lost birthday) yrs. <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ireland</u>		14. MOTHER'S MAIDEN NAME <u>Clementine Michel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Frank Scholz - 4511 Rehmann Ave.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Natural Causes</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 3, 1956</u> to <u>April 12, 1956</u> , that I last saw the deceased alive on <u>April 12, 1956</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles Tommasello</u> M.D.		910 W. Lombard St.	
PHYSICIAN'S NAME (Type) <u>Charles Tommasello</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Luff</u>	

RECEIVED

APR 16 1956

BUREAU V. S.

1. Name of deceased: *John Doe*
2. Date of death: *April 15, 1956*
3. Place of death: *New York City, New York*
4. Cause of death: *Heart disease*
5. Age at death: *65*
6. Sex: *Male*
7. Race: *White*
8. Marital status: *Married*
9. Occupation: *Teacher*
10. Education: *High School Graduate*
11. Religion: *Catholic*
12. Social Security Number: *123-45-6789*
13. Name of informant: *John Doe*
14. Address of informant: *123 Main St, New York City, NY*
15. Signature of informant: *[Signature]*
16. Date of report: *April 16, 1956*

17. Name of physician: *Dr. John Smith*
18. Address of physician: *456 Main St, New York City, NY*
19. Signature of physician: *[Signature]*
20. Date of report: *April 16, 1956*

21. Name of funeral home: *ABC Funeral Home*
22. Address of funeral home: *789 Main St, New York City, NY*
23. Signature of funeral home: *[Signature]*
24. Date of report: *April 16, 1956*

25. Name of coroner: *John Doe*
26. Address of coroner: *123 Main St, New York City, NY*
27. Signature of coroner: *[Signature]*
28. Date of report: *April 16, 1956*

CERTIFICATE OF DEATH

3000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH

03714

3752

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>COCKEYSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HILLSIDE AVE</u>		STREET ADDRESS (If rural, give location) <u>HILLSIDE AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ROSA</u> (Middle) <u>MAY</u> (Last) <u>JACKSON</u>	4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>24</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>3-7-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house</u>	9. AGE last birthday <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY SMITH</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH YOUNG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>BERTHA JACKSON COCKEYSVILLE</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> Immediate cause (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		<u>5 YRS</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE William A. Pinesbury M.D. (Degree or title) DATE SIGNED 4/24/56

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 4-27-56 NAME OF CEMETERY OR CREMATORY Basil A.H.E. LOCATION (City, town, or county) Cockeysville Md (State)

DATE REC'D BY LOCAL REG. 26 April 1956 REGISTRAR'S SIGNATURE Dunn Carmichael MacPae 24. FUNERAL DIRECTOR F. Scott Brooks, Sparks, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 30 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03715

3753

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>SPRUE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>EDGEWATER (191)</u>		LENGTH OF STAY (In this place) <u>30 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>AS ME</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8802 RIVER DRIVE Rd.</u>				STREET ADDRESS <u>#1</u>		(If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>LYDIA MARIA JARVINEN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4-8-1956</u>			
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug. 23, 1890</u>		9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>FINLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>FINLAND</u>	
13. FATHER'S NAME <u>ARON CALLIO</u>				14. MOTHER'S MAIDEN NAME <u>HILMAN (DNR)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>EMIL JARVINEN - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Acute Coronary Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Ht. Disease</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1954</u> to <u>April 1956</u> that I last saw the deceased alive on <u>4-8-1956</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. J. Means</u>		DATE THEREOF <u>4-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		LOCATION (City, town, or county) <u>BALTO. CO. MD</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Apr. 10-56</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>		Funeral Director's Signature <u>Arthur George Doolittle, Jr., Dundalk, Md.</u>		ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3754

CERTIFICATE OF DEATH

03716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>12 Days</u>				d. STREET ADDRESS <u>3403 Boston Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>S</u> Last <u>JENKINS</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30, 1892</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>4</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William S. Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Effie May Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-12-0704</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, LEFT UPPER LOBE</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>VA</u> Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>March 23</u> , 19 <u>56</u> , to <u>April 4</u> , 19 <u>56</u> . That I saw the deceased alive on <u>March 23</u> and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald D. Mark</u>				ADDRESS (Street, city or town, state) <u>VAH Ft. Howard, Md</u> DATE SIGNED <u>4/4/56</u>			
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>				<u>VAH, FORT HOWARD, MD</u> <u>4/4/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Road, Balto. Md</u>				24a. REC'D BY REGISTRAR <u>APR 9 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1956

RECEIVED

3658

CERTIFICATE OF DEATH

03717/
Reg. Dist. No. 7/

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 53 TOWN Dundalk		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL OR and give nearest town) 53 TOWN Dundalk			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3409 Liberty Parkway				STREET ADDRESS (If rural give location) 3409 Liberty Parkway			
3. NAME OF DECEASED: (First) WILLIAM		(Middle) F. (KAHLERT)		(Last) KAHLER		4. DATE OF DEATH: April 4, 19 56	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH: Ja. 3, 1871	
9. AGE last birthday: 85 yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Watchman-ret.		11. BIRTHPLACE (State or foreign country): Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Mrs. Margaret Kahler, Cambridge Arms Apts,			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause (a) Congestive Heart Disease				2 days			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis, generalized				4 years			
(c) Diabetes Mellitus				4 years			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetic gangrene with bilateral amputation							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 19 55, to 4 April, 19 56, that I last saw the deceased alive on 3 April, 19 56, and that death occurred at 11 A.M. 4 April 19 56, from the causes and on the date stated above. SIGNATURE Morris Rainess, M.D. ADDRESS 2900 Dunbar Rd. Balto. 22 DATE SIGNED 5 April 19 56							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		April 7, 1956		Oak Lawn Cemetery		Colgate, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
April 7-1956		William M. Kelly		Ullrich Funeral Home 2112 Dundalk Ave.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 18 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3755

CERTIFICATE OF DEATH

03718

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> 13X-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hospital</u>				d. STREET ADDRESS <u>Delchester Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MAE</u> Last <u>KERGER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 4 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHIRT MFGR</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WILLIAM H. CHAFFMAN</u>				14. MOTHER'S MAIDEN NAME <u>LENA PARKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>HENRY KERGER</u> Address <u>Delchester Road Ellicott City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Aneurysm</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Senility & Secondary Severe Dehydration & Malnutrition</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/13</u> , 19 <u>52</u> , to <u>4/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph R Cowen</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove Hospital</u> DATE SIGNED <u>4/2/56</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH R. COWEN</u>				<u>SPRING GROVE HOSPITAL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, CATONSVILLE, MD.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>4/3/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>T.E. Harry</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1910</i>		6. PLACE OF BIRTH <i>Baltimore, Md</i>	
7. DATE OF DEATH <i>Apr 10 1956</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Myocardial Infarction</i>	
11. DISEASE OR INJURY <i>Coronary Artery Disease</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>	
15. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		16. SIGNATURE OF FUNERAL HOME <i>John Doe</i>	
17. SIGNATURE OF BURIAL PLACE <i>John Doe</i>		18. SIGNATURE OF OTHER <i>John Doe</i>	

RECEIVED
APR 4 1956
BUREAU V. S.

3756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 30 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03720

3757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>29</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spry Grove Hospital</u>		d. STREET ADDRESS <u>4305 Wilkens Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>WALSH</u> Last <u>KIRWAN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1956</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-1885</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Walsh</u>		14. MOTHER'S MAIDEN NAME <u>Helen Goodrich</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-28-3795 B</u>			
17. INFORMANT <u>Mr. Albert N. Kirwan - 4305 Wilkens Ave.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiac Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson Disease + Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>3-23</u> , 19 <u>56</u> , to <u>4-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>56</u> , and that death occurred at <u>7:45 p.m.</u> , from the causes and on the date stated above.		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) <u>Woodlawn, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickener & Sons - Balt</u>		24a. ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Harry</u>			

MEDICAL CERTIFICATION

BUREAU V. S.

APR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3758

CERTIFICATE OF DEATH

03721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Belinda Ave.</u>		d. STREET ADDRESS <u>19 Belinda Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>H.</u> Last <u>Kreager</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1869</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Rohde</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward Kreager</u> Address <u>19 Belinda Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 27, 19 56</u> to <u>April 23, 19 56</u> , that I last saw the deceased alive on <u>April 23, 19 56</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Adam G. Swiss</u> M.D.		DATE SIGNED <u>1956</u>	
PHYSICIAN'S NAME (Type) <u>ADAM G SWISS</u>		<u>6232 Belair Rd. Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 26, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>APR 30 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Ruffenberger</u>	

BUREAU V. 3

APR 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0372233

3759

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>107 Dean Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Frederick</u> Last <u>Krieg</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/36</u>
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James William Krieg</u>		14. MOTHER'S MAIDEN NAME <u>Anna Leona Connelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd Ventricular tumor with internal hydrocephalus</u> <u>754.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and cessation of respiration.</u> DUE TO (c) <u>Lung edema, failure of heart.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Birth c</u> <u>Tuberous</u> <u>sclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberose Sclerosis with symptomatic Epilepsy</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) (State)	
21. I certify that I attended the deceased from <u>August 20,</u> 19 <u>56</u> , to <u>April 8,</u> 19 <u>56</u> , that I last saw the deceased alive on <u>April 8,</u> 19 <u>56</u> , and that death occurred at <u>7:00A</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u> </u> <u>4/10/56</u>			
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M. D.</u> <u>Rosewood St. Tr. School, Owings Mills, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>April 10/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline - Sons Rustington</u>		24a. REC'D BY REGISTRAR DATE <u>4-10-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B Eline</u>			

BUREAU V. S.

12 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03723

3760 **CERTIFICATE OF DEATH**

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore Zone 7</u>		LENGTH OF STAY (In this place) <u>8 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore Zone 7</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5619 Carroll Ave</u>				STREET ADDRESS (If rural give location) <u>5619 Carroll Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE KRUG Sr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 24, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>Jan. 11, 1878</u>	
9. AGE last birthday <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Continental Can Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Frederick Krug</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-05-3678</u>				17. INFORMANT & ADDRESS <u>Baltimore - 7, Md. Mrs. George Brookhart 5619 Carroll Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary sclerosis; myocardial degeneration</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <u>11-1</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-1</u> , 19 <u>51</u> , to <u>4-25</u> , 19 <u>56</u> that I last saw the deceased alive on <u>4-21</u> , 19 <u>56</u> , and that death occurred at <u>3:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Hapness</u>				DATE SIGNED <u>4-25-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 27, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4/26/56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>		ADDRESS <u>Catonsville, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0372430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. LENGTH OF STAY IN 1b 1mo. 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) 14 Spring Grove State Hospital		d. STREET ADDRESS 748 McHenry Street	
3. NAME OF DECEASED (Type or print) JOHN J. KUMMEL		4. DATE OF DEATH Month April Day 30 , Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Suchtungs Co.	
11. BIRTHPLACE (State or foreign country) Maryland BALTO.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Kummel		14. MOTHER'S MAIDEN NAME Eva Braun	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-2 , 19 56 , to 4-30 , 19 56 , that I last saw the deceased alive on 4-30 , 19 56 , and that death occurred at 6:11 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel Edwards M.D.		ADDRESS (Street, city or town, state) Spring Grove Hospital Catonsville, 28, Md.	
DATE SIGNED 4-30-56			
PHYSICIAN'S NAME (Type) David Edwards, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/56	
22c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.		22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan		24a. REC'D BY REGISTRAR Rollins	
ADDRESS St.		24b. REGISTRAR'S SIGNATURE T. E. Harry	
DATE 5/1/56			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

3762

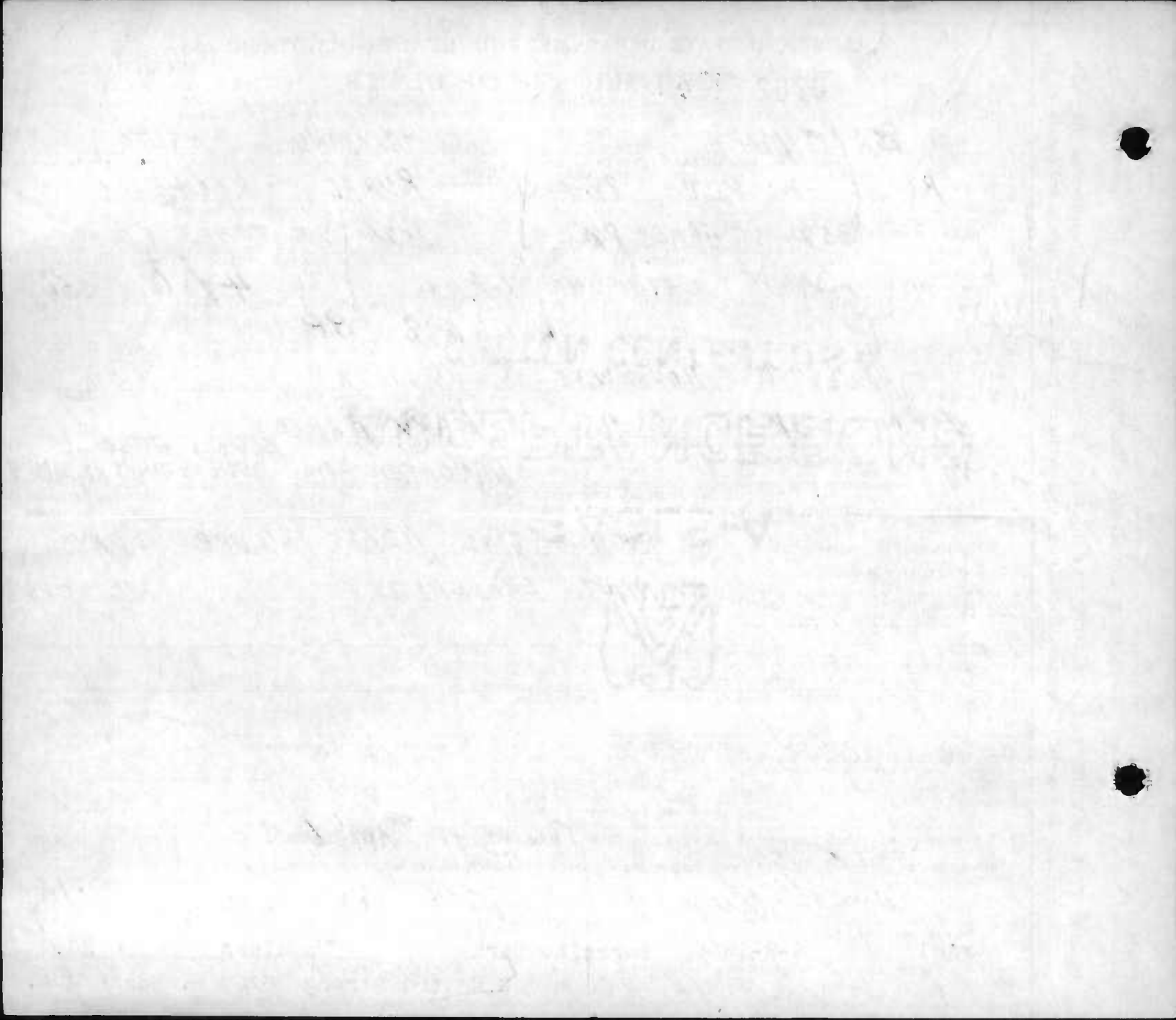
CERTIFICATE OF DEATH

03725 31
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE MARYLAND				STATE MARYLAND COUNTY BALTO.			
CITY (If outside corporate limits, write RURAL or an give nearest town) RURAL - ROCKDALE				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL - ROCKDALE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3524 ST. JAMES Rd.				STREET ADDRESS (If rural give location) 3524 ST. JAMES Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last) FANNIE CATHERINE LAKE				4. DATE (Month) (Day) (Year) OF DEATH: 4/6 1956			
5. SEX: F		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED		8. DATE OF BIRTH: APRIL 1, 1868	
9. AGE last birthday: 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE		11. BIRTHPLACE (State or foreign country): VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JACOB ESTEP				14. MOTHER'S MAIDEN NAME: MARK BARTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. —			
17. INFORMANT & ADDRESS: EDWARD WEBER. DAUGHTER - MRS. 3524 ST. JAMES RD, BALTO. 7							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) CONGESTIVE HEART FAILURE						3 DAYS.	
ANTECEDENT CAUSE (B) ACUTE BRONCHITIS						ONE WEEK.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEBRUARY, 1950 , to APRIL 6, 1956 , that I last saw the deceased alive on APRIL 5, 1956 , and that death occurred at 1:50 A.M. , from the causes and on the date stated above.							
SIGNATURE Edwin J. Pierpont				ADDRESS 8204 LIBERTY RD, BALTO. MD.		DATE SIGNED 4/6/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-9-1956		NAME OF CEMETERY OR CREMATORY Lorraine Park		LOCATION (City, town, or county) (State) Woodlawn Md.	
DATE REC'D BY LOCAL REGISTRAR April 6/1956		REGISTRAR'S SIGNATURE C. W. Hedrich		24. FUNERAL DIRECTOR G. Howard Strong		ADDRESS 3207 W. North Ave.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3763

CERTIFICATE OF DEATH

Reg. D. 03726³⁰

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1511 Midvale Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary E. Thompson Lanowitz</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>27</u> Year <u>19 56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1875</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Emily</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Leroy Thompson, 1511 Midvale Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 5, 1944</u> to <u>April 26, 1956</u> , that I last saw the deceased alive on <u>April 26, 1956</u> , and that death occurred at <u>2:5 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1326 N. Lombard St.</u> DATE SIGNED <u>April 30, 1956</u>			
ACTUAL SIGNATURE <u>Carl P. Roetling</u>		M.D. <u>1326 N. Lombard St.</u>	
PHYSICIAN'S NAME (Type) <u>CARL P. ROETLING</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 1/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

RECEIVED

MAY 1 1956

BUREAU V. S.

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. TIME OF DEATH	
5. SEX		6. AGE	
7. OCCUPATION		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED	
47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED	
63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED	
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77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED	
87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

CERTIFICATE OF DEATH

6763

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03727
10

3764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8months11days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 1953 W. Fayette Street	
3. NAME OF DECEASED (Type or print) Isabelle First Lawless Last		4. DATE OF DEATH Month April Day 12, Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-1890
9. AGE (In years lost birth day) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen Campbell		14. MOTHER'S MAIDEN NAME Hettie & Mary-G. Kane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1- 19 55 , to 4-12- 19 56 that I last saw the deceased alive on 4-12-56 , 19 56 , and that death occurred at 9:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4-12-56			
ACTUAL SIGNATURE Stella Wachsler		M.D. Spring Grove State Hospital	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/56	
22c. NAME OF CEMETERY OR CREMATORY New Balto. National Cem.		22d. LOCATION (City, town, or county) (State) 5301 Frederick Ave	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan		ADDRESS 55 Collins St.	
24a. REC'D BY REGISTRAR APR 10 1956		24b. REGISTRAR'S SIGNATURE J. B. Hays	

11

BUREAU V. S.

APR 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3765 CERTIFICATE OF DEATH

03728

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE MD.</u>		LENGTH OF STAY (in this place) <u>3 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		TOWN <u>3701.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Home</u>				STREET ADDRESS (If rural give location) <u>514 S. COLLINS AVE.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WALTER C. LEDLEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 7 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10/12/1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile Co.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward C. Ledley</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-4326</u>		17. INFORMANT & ADDRESS <u>Mrs. Rachel C. Ledley 514 S. COLLINS AVE.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>493X</u>				ANTECEDENT CAUSE(S) DUE TO <u>Myocardial Infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO <u>Pleurisy & effusion</u>			
				(C) DUE TO <u>Pneumonia</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 months</u> <u>4 months</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12.18.1955</u> to <u>4.7.56</u> , that I last saw the deceased alive on <u>4.7.56</u> , 19 <u>56</u> , and that death occurred at <u>9:54</u> M., from the causes and on the date stated above.							
SIGNATURE <u>George J. Utman</u>				ADDRESS (Street, city, town, state) <u>805 Dredrick Ave 28 Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>London Park Cem</u>		LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 10 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Freeman Schwalb</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	

CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Sex

Age

Occupation

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Physician's Signature

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

Signature of Clerk

Signature of Nurse

Signature of Doctor

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

BUREAU V. S.

APR 10 1956

RECEIVED

3766

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH o. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN life life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Run Rd.		d. STREET ADDRESS Western Run Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Adam Last Lee		4. DATE OF DEATH Month 4 Day 22 Year 56	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1900
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR: Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) minister		10b. KIND OF BUSINESS OR INDUSTRY methodist church	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Lee		14. MOTHER'S MAIDEN NAME Emma Meyers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-18-9941	
17. INFORMANT Mrs. Madeline Lee, Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension & DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ✓			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-22-56 19, to 4-22-56 19, that I last saw the deceased alive on 4-22-56 19, and that death occurred at 9 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. Raffell M.D.		ADDRESS (Street, city or town, State) Reisterstown, Md	
PHYSICIAN'S NAME (Type) James B. Raffell		DATE SIGNED 4-24-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-56	
22c. NAME OF CEMETERY OR CREMATORY Gough's Methodist		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		ADDRESS Sparks, Md.	
24a. REC'D BY REGISTRAR 26 April 56		24b. REGISTRAR'S SIGNATURE Ann Ernestine MacRae	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE	
JAMES EARL RAY		Male		35		White		1928		Missouri		1954		Missouri	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
Actor		Suicide		Suicide		Home		April 4, 1968		4:30 PM		[Signature]		[Signature]	
17. HISTORY OF ILLNESS		18. PRESENT ILLNESS		19. MEDICAL HISTORY		20. SURGICAL HISTORY		21. SOCIAL HISTORY		22. FAMILY HISTORY		23. PERSONAL HISTORY		24. OTHER HISTORY	
[Faded text]		[Faded text]		[Faded text]		[Faded text]		[Faded text]		[Faded text]		[Faded text]		[Faded text]	

BUREAU V. S.

APR 30 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03730

3767

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 14 yr 11 mo. 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) 14 Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Valeria (Walerja) Lewandowski				4. DATE OF DEATH Month Day Year April 5, 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-1894	
9. AGE (In years last birthday) 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Unknown				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Records Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Regurgitation of food into bronchus DUE TO (c) Severe Parkinson's Disease							INTERVAL BETWEEN ONSET AND DEATH 15 minutes 15 minutes 25 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inanition							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Spring Grove State Hospital				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7 _____, 19 53 , to 4-5 _____, 19 56 that I last saw the deceased alive on 4-5 _____, 19 56 , and that death occurred at 11:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4-5-56							
ACTUAL SIGNATURE Stella Wachslar				M.D. Spring Grove State Hospital			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-1956		22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) Frederick Rd., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 824 Hudson St.				ADDRESS		24a. REC'D BY REGISTRAR DATE 10 1956	
				24b. REGISTRAR'S SIGNATURE P. E. Harris			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		1-22-29		MEMPHIS, TENN.		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		TREATMENT		POST-MORTEM	
4-4-68		MEMPHIS, TENN.		SHOOTING		SUICIDE		SHOOTING		NO		NO		NO	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION	
12:00 PM		12		00		00		98.6		60		120/80		16	
DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY		DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
4-10-68		MEMPHIS, TENN.		MEMPHIS		TENNESSEE		UNITED STATES		4-10-68		MEMPHIS, TENN.		MEMPHIS	
DATE OF REPORT		PLACE OF REPORT		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY	
4-10-68		MEMPHIS, TENN.		MEMPHIS		TENNESSEE		UNITED STATES		4-10-68		MEMPHIS, TENN.		MEMPHIS	

BUREAU V. F.

APR 10 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3768 Item 3, Film G186 Jan 26, 56
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 2mos. 20days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1011 MALDEIS ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE W. LEWIS				4. DATE OF DEATH Month APRIL Day 18 Year 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 8, 1886	
9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Watchman, Balto. Paint		10b. KIND OF BUSINESS OR INDUSTRY Color Wrks.		11. BIRTHPLACE (State or foreign country) Hermit Pa.	
13. FATHER'S NAME Grant Griffith				14. MOTHER'S MAIDEN NAME Leah Griffith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 214-1474657A		17. INFORMANT Records Spring Grove State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suppurative nephritis DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 31 , 19 56 , to Apr - 18 , 19 56 , that I last saw the deceased alive on April 18 , 19 56 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome E. Shapiro M.D.				ADDRESS (Street, city or town, state) Spring Grove State Hosp			
PHYSICIAN'S NAME (Type) Jerome E. Shapiro, M. D.				DATE SIGNED 4/19/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witte				ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR APR 23 1956	
				24b. REGISTRAR'S SIGNATURE V. E. Shays			

BUREAU V. S.

APR 23 1956

RECEIVED

03732

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3670

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Landsdown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Landsdown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4021 Hollins Ferry Rd.</u>		STREET ADDRESS (If rural, give location) <u>4021 Hollins Ferry Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Patty</u> (Middle) <u>Marie</u> (Last) <u>Lindblade</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>26</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 17, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>0</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Andrew Lindblade</u>		14. MOTHER'S MAIDEN NAME <u>Patricia MacFord</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>4021 Hollins Ferry Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

751X Immediate cause

(a)

Pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Spina - bifida

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/17, 1956, to 4/26, 1956, that I last saw the deceasedalive on 4/12, 1956, and that death occurred at 11:00 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

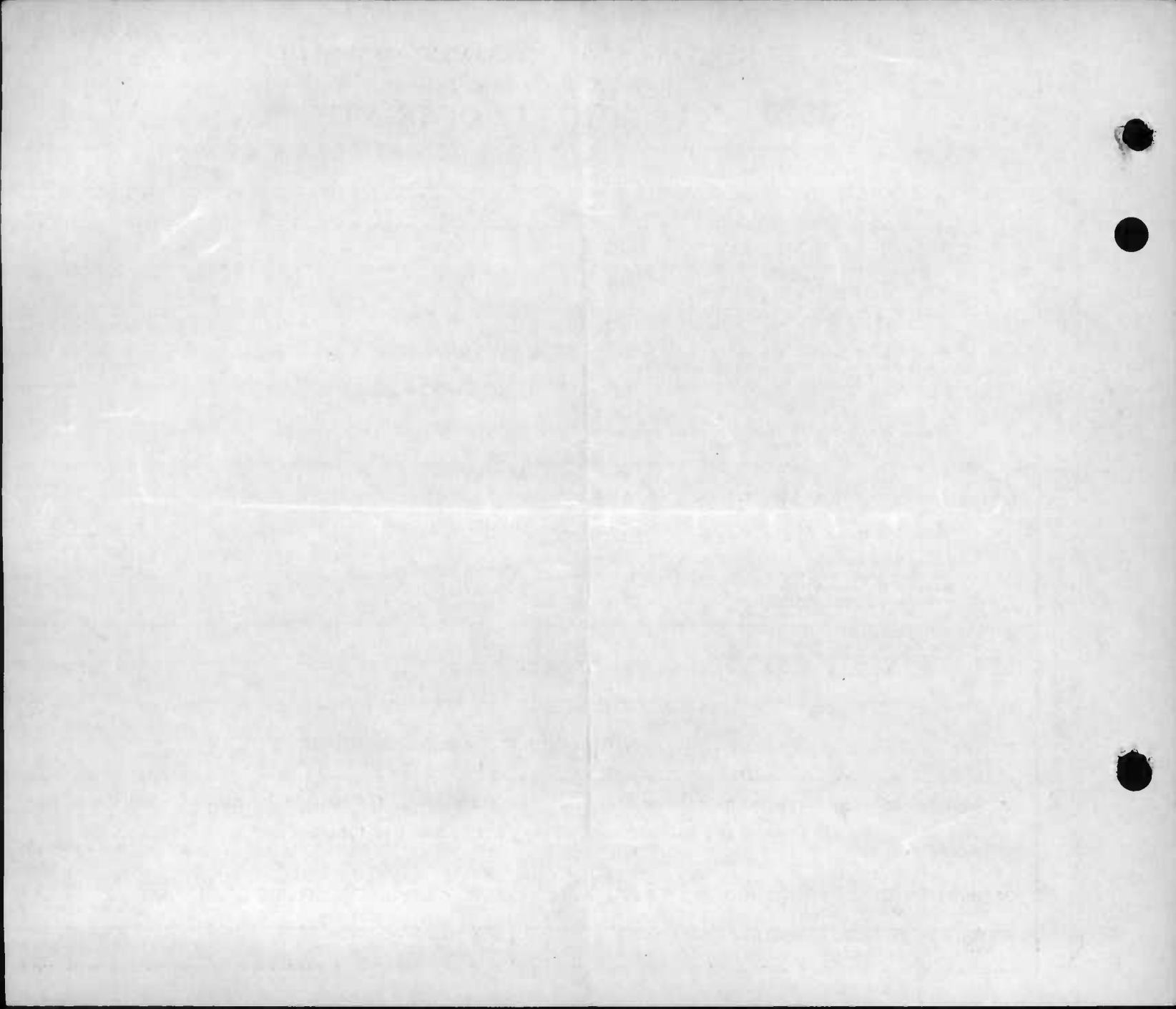
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



03733

3769

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>887 Hamilton Place - Lavy, Maryland</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>7</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F</u> Last <u>Lindenmayer</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Charles Lindenmayer - 2026 Chamberlane Ave. Richmond, Virginia</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour a. ft. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-14-1956</u> to <u>4-9-1956</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachler</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u> DATE SIGNED <u>4-9-56</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		<u>Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>APR 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CREMATION</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Cook / Dudley, Harlock, 1401</u>		24. REC'D BY REGISTRAR DATE <u>APR 11 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>V. E. Harry</u>			

BUREAU V. S.

APR 11 1956

RECEIVED

Reg. Dist. No.

3770

1. PLACE OF BIRTH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIUS		4. DATE OF DEATH 4-29-56	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-98	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. 10 Months 10 Days 10 Hours 10 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) Germany		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Kathleen	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		17. SOCIAL SECURITY NO. Unknown	
18. INFORMANT Records Spring Grove Hosp.		19. ADDRESS Spring Grove Hosp.	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) general debility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24b. (City or town) (County) (State)	
25. I certify that I attended the deceased from 4-19-56 to 4-29-56 , that I last saw the deceased alive on 4-29-56 , and that death occurred at 10:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove Hospital Catonsville, Md. DATE SIGNED			
26. ACTUAL SIGNATURE David Edwards MD		27. PHYSICIAN'S NAME (Type) DAVID EDWARDS MD	
28a. BURIAL, CREMATION, REMOVAL (Specify) Buried		28b. DATE THEREOF May 2-1956	
28c. NAME OF CEMETERY OR CREMATORY Cedar Hill		28d. LOCATION (City, town, or county) (State) Ritchie Highway Md.	
29. FUNERAL DIRECTOR'S SIGNATURE Kramer Funeral Home		30. ADDRESS 1216 S Charles St.	
31a. REC'D BY REGISTRAR DATE 5/4/56		31b. REGISTRAR'S SIGNATURE Victor C. Nary	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Ord. No.

8770

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1901</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1956</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1956</u></p>		<p>12. Place of registration: <u>BALTIMORE</u></p>	

BUREAU V. 5

MAY 4 1956

RECEIVED

03735

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

3771

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Quaker Bottom Rd.</u>		STREET ADDRESS (If rural, give location) <u>Quaker Bottom Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>BLANCHE</u> (Middle) <u>PEARL</u> (Last) <u>VINLA MADDEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 22 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>NOV. 27 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE last birthday <u>47</u> yrs. If under 1 year: Months Days Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN JENKINS</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE PAXTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>215-22-3862</u>	
17. INFORMANT AND ADDRESS <u>Flla I Ringgold, Cockeysville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
170x Immediate cause (a) <u>CARCINOMA OF BREAST</u> Antecedent cause(s) (b) _____ Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		<u>2 YRS</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
SIGNATURE <u>William A. Pillsbury</u> (Degree or title) <u>M.D.</u>		DATE SIGNED <u>4/22/56</u>
23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF <u>2-26-56</u>	NAME OF CEMETERY OR CREMATORY <u>Stephenson A.M.E.</u>
LOCATION (City, town, or county) <u>Sparks, Md.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>26 April 1956</u>	REGISTRAR'S SIGNATURE <u>June Annistead MacBride</u>	24. FUNERAL DIRECTOR <u>Scott Brooks</u> ADDRESS <u>Sparks, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 30 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03736

3659

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>30 Eastship</u>		STREET ADDRESS (If rural, give location) <u>30 Eastship</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>L.</u> (Middle) <u>Makin</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 1956</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 8, 1873</u>
9. AGE last birthday <u>82</u> yrs.		10. If under 1 year Months. Days Hours. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>M.C. Harlow</u>		14. MOTHER'S MAIDEN NAME <u>E.T. Falls</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>John B. Henderson 30 Eastship</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause (a) <u>Arteriosclerotic cardio-vascular disease</u>		
Antecedent cause(s) (b) <u>Senility</u>		<u>5 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		<u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 45, 1945, to April 1, 1956, that I last saw the deceased alive on March 25, 1956, and that death occurred at 12:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

David H. Andrew M.D. 33 Dundalk Ave Dundalk Md 21226 April 2 1956

23. BURIAL, CREMATION, REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

April 3, 1956 A. W. Hedrick Ullrich Funeral Home 2112 Dundalk Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

IN SENATE,
JANUARY 11, 1901.

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.

THE COMMISSIONER OF THE LAND OFFICE,
DALLAS, TEXAS.

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.

THE COMMISSIONER OF THE LAND OFFICE,
DALLAS, TEXAS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

037374

Reg. Dist. No.

3772

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastwood				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7701 Eastdale Road				e. STREET ADDRESS 7701 Eastdale Road			
3. NAME OF DECEASED (Type or print) First ROBERT Middle WILSON Last MANGUM				4. DATE OF DEATH April 29 Month April Day 29 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1935	9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months 21 Days 19 Hours 56 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Woodrow Mangum				14. MOTHER'S MAIDEN NAME Rita Laird			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes Navy		16. SOCIAL SECURITY NO. current		17. INFORMANT Woodrow Mangum, father, 7701 Eastdale Road Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x GUN SHOT WOUND (22 CAL RIFLE) - Conditions, if any, which gave rise to immediate cause (b) THRU BRAIN-ENTERING BETWEEN EYES + (c) THRU RUNNING UPWARDS DUE TO RUNNING UPWARDS				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SHOT SELF THRU HEAD					
20c. TIME OF INJURY Month, Day, Year 4-25 4-29-56 Hour 4:25 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) EASTWOOD - BALTO - MD (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. DAVIS MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, 2601 E. Madison St. Baltimore, 5, Md. ADDRESS				24a. REC'D BY REGISTRAR 5/2/56 DATE		24b. REGISTRAR'S SIGNATURE Wm. P. Kelly	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case should be filed with the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, date of death, and cause of death. The form is mostly blank, with some faint text visible in the background.

BUREAU V. S.

MAY 2 1956

RECEIVED

03738

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edisonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 3 Vol-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines</u>		STREET ADDRESS (If rural, give location) <u>6921 Reservoir Road</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>SARAH</u>			<u>MARKS</u>
4. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
			<u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
<u>House wife</u>		<u>Manchester Eng</u>	<u>U.S.A</u>
13. FATHER'S NAME <u>Simon</u>	14. MOTHER'S MAIDEN NAME <u>Lena</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Albert Marks - Same</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ---

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ---

(c) ---

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1 week10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11, 1956, to 4/15, 1956, that I last saw the deceased alive on 4/14, 1956, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

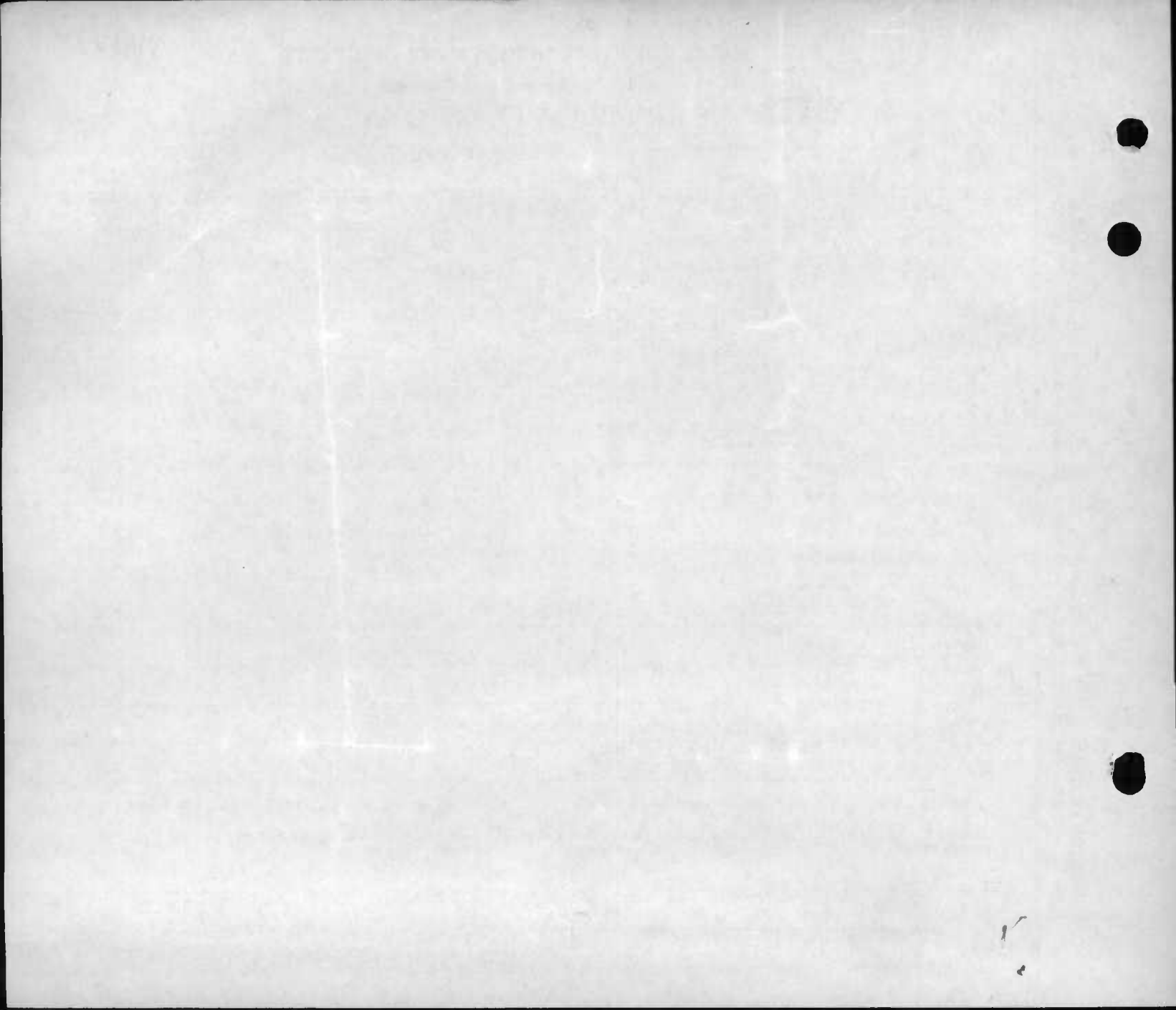
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Cremation</u>	<u>4-16-56</u>	<u>Rosedale</u>	<u>Balto</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 16, 1956</u>	<u>W. H. H. Edgely</u>	<u>Jack Lewis</u>	<u>2100 Eutan Rd</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03739

3774

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 25 Edmondson Ridge Rd.				STREET ADDRESS (If rural give location) 25 Edmondson Ridge Rd.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JAMES		(Middle) HENRY		(Last) MARSH		(Month) (Day) (Year) Apr. 14, 1956	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Dec. 16, 1877	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ship Builder Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James T. Marsh				14. MOTHER'S MAIDEN NAME Sarah Snowden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 215-03-2895		17. INFORMANT & ADDRESS Mr. John A. Harrison, Sr. - 25 Edmondson Ridge Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
241X IMMEDIATE CAUSE (A) G.P.C. of Lung						1 da	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cardiovascular Disease - Emphysema -						3 yrs	
(C) Bronchitis - Asthma -							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 2 , 19 56 , to Apr 14 , 19 56 , that I last saw the deceased alive on Apr 14 , 19 56 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
SIGNATURE Dr. Edwin W. Koons		M.D. 1202 8th Ave		ADDRESS (Street, city, town, state) Balto., Md.		DATE SIGNED 4/16/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/18/56		NAME OF CEMETERY OR CREMATORY London Park Cem.		LOCATION (City, town, or county) (State) Balto., Md.	
24. REC'D BY REGISTRAR DATE APR 20 1956		REGISTRAR'S SIGNATURE T. E. Hays		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tranev		ADDRESS 4605 Baito Md	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

CAUSE OF DEATH

PLACE OF BIRTH

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PLACE OF BIRTH

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PLACE OF BIRTH

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CAUSE OF DEATH

PLACE OF BIRTH

SEX

AGE

CAUSE OF DEATH

PLACE OF BIRTH

BUREAU V. S.

APR 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3775

CERTIFICATE OF DEATH

Reg. Dist. No.

037440

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillside Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN E. MAYNARD		4. DATE OF DEATH Month April Day 27th Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1920
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond R. Dilworth		14. MOTHER'S MAIDEN NAME Mabel C. Dilworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Mr. Raymond L. Maynard, Hillside Rd., Kingsville Md.	
17. INFORMANT Mr. Raymond L. Maynard, Hillside Rd., Kingsville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scirrhus Carcinoma of duct of breast with wide spread Metastasis DUE TO (b) 170x DUE TO (c) 39 Month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/21/48 , 19 56 , to 4/27 , 19 56 , that I last saw the deceased alive on 2/26 , 19 56 , and that death occurred at 5:40 P.M. , from the causes and on the date stated above. Signature Clifford F. Hudson M.D. ADDRESS Fork, Md. DATE SIGNED 4/28/56 PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/30/56	
22c. NAME OF CEMETERY OR CREMATORY Fork Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Fork, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassiter Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE 30 1956		24b. REGISTRAR'S SIGNATURE Dr. Walter Hemmelt	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03742

3776

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Riderwood, Baltimore</u> <u>MARYLAND</u> County <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>624 S. Bond Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sorensen Nursing Home</u>		d. STREET ADDRESS <u>7912 Ruxway Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MAYO</u> Last <u>MAYO</u>		4. DATE OF DEATH Month <u>April</u> Day <u>eleventh</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>industrialman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Mandrio Province,</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Argentina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not known</u>		16. SOCIAL SECURITY NO. <u>217-14-0590</u>	
17. INFORMANT <u>Frank Michalski, 624 S. Bond Street</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricle failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertrophy myocardium with weakness</u> DUE TO (c) <u>Myocarditis chronic.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>few months</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac asthma associated with left ventricular failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 <u>19</u> p. m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>no injury</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no injury</u>		20f. (City or town) (County) (State) <u>no injury</u>	
21. I certify that I attended the deceased from <u>Dec. 30th, 1955</u> , to <u>April 11, 1956</u> , that I last saw the deceased alive on <u>April seven, 1956</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James Graham Marston</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>516 Cathedral Street</u> <u>4-11-56</u>	
PHYSICIAN'S NAME (Type) <u>James Graham Marston, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		24a. REC'D BY REGISTRAR <u>APR 16 1956</u>	
ADDRESS <u>1217 St. Paul Street</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Skye</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. S.

APR 16 1956

RECEIVED

3777 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Rural: Towson</u>		<u>2 weeks</u>		OR TOWN <u>Baltimore City</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium</u>				STREET ADDRESS (If rural give location) <u>1733 N. Payson St.</u>			
3. NAME OF DECEASED: (First) <u>ENOS</u> (Middle) <u>Elmer</u> (Last) <u>Mellott</u>				4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>9/24/05</u>	
9. AGE last birthday: <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Meat Cuts Army Commissary</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore City</u>			
11. BIRTHPLACE (State or foreign country): <u>US</u>				12. CITIZEN OF WHAT COUNTRY: <u>US</u>			
13. FATHER'S NAME: <u>ENOS E Mellott</u>				14. MOTHER'S MAIDEN NAME: <u>Rose Shipley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>215-03-6958</u>		17. INFORMANT & ADDRESS: <u>Personal History</u>	
				<u>Hospital Records, Eudowood Sanatorium</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset and Death	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Hypertensive Cardiovascular Disease</u>		<u>6 mos.</u>	
Antecedent causes (s) (b) <u>Coronary Involvement, Antero-lateral Myo-cardial Damage</u>		<u>4 mos.</u>	
DUE TO (c)			

II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 3/28, 1956, to 4/13, 1956, that I last saw the deceased alive on 4/13, 1956, and that death occurred at 3:10 PM, from the causes and on the date stated above.

SIGNATURE <u>William B. Kuss M.D.</u>		ADDRESS <u>Eudowood Sanatorium - Towson 4, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Burial</u>		<u>April 16-1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>MT. OLIVET CEM.</u>		<u>BALTO. MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>APR 15 1956</u>		<u>W. Truman Schwalb</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>W. Truman Schwalb</u>		<u>3512 Frederick Ave. (29)</u>	

MARGIN RESERVED FOR BENDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3778

CERTIFICATE OF DEATH

Reg. Dist. No.

03744
30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>14yr5mo18days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>132 West Clement Street</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>S.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1893</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Bn</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank P. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Laura Sholtz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old extensive myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Pneumogitis due to failing heart</u> INTERVAL BETWEEN ONSET AND DEATH <u> </u> years <u> </u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema, terminal</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2</u> <u>1953</u> , to <u>4-23</u> <u>19 56</u> , that I last saw the deceased alive on <u>4-23</u> <u>19 56</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u> DATE SIGNED <u>4-23-56</u>			
ACTUAL SIGNATURE <u>Stella Wachslor</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslor, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 26, 1956</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Al Howard Evans</u>		ADDRESS <u>1400 E. Charles St</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	

RECEIVED

APR 25 1956

BUREAU V. 5

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03745

3779

CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>36yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Carmel Rd.</u>		d. STREET ADDRESS <u>Mt. Carmel Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>K.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. D. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Miller</u>		14. MOTHER'S MAIDEN NAME <u>Sarepta Gore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-18-4468</u>	
17. INFORMANT <u>Mrs. Martha Miller, Parkton, Md. R.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardiac Vascular Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 1</u> , 19 <u>56</u> , to <u>Apr. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr. 1</u> , 19 <u>56</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>Apr. 1, 56</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		<u>NAKPSFEAD MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Karlenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE 4/4/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert J. Fiedler</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3780

CERTIFICATE OF DEATH

Reg. Dist. No.

03746³³⁻

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. LENGTH OF STAY IN 1b <u>62 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>York Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Vernon</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1893</u>	
9. AGE (In years last birthday) <u>62 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Beckleysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James C. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Clara McCullough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>214-225424</u>		17. INFORMANT Address <u>Mrs. Lillian Miller, Parkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>12/31</u> , 19 <u>55</u> , to <u>4/6/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/31</u> , 19 <u>55</u> , and that death occurred at <u>12/31 AM</u> , from the causes and on the date stated above. <u>4/5/56</u> ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>4/7/56</u>							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. <u>Parkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 8, 1956</u>		<u>Wiseburg Cemetery</u>		<u>White Hall, Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Nordenshtein, New Freedom, Pa.</u>				24. REC'D BY REGISTRAR DATE <u>4/7/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Fulton</u>	

BUREAU V. S.

APR 10 1956

RECEIVED

3781

CERTIFICATE OF DEATH

03747

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a.a.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>68 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>STANLEY A. MOCARSKY</u>				4. DATE OF DEATH <u>April 3 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1914</u>		9. AGE (In years lost birthday) <u>41 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Business</u>		11. BIRTHPLACE (State or foreign country) <u>Springfield, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				13. FATHER'S NAME <u>Stanley A. Mocarsky</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth (Unknown)</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>217-14-5762</u>				17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYELOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>203X</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>VA</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>January 26, 1956</u> , to <u>April 3, 1956</u> , that I saw the deceased alive on <u>April 3, 1956</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald D. Mark</u>				ADDRESS (Street, city or town, state) <u>VAH Ft. Howard, Md</u>			
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>				DATE SIGNED <u>4/4/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Cvach Funeral Home</u>				ADDRESS <u>900 N. Chester St. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 6 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dawson L. Fisher</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3721

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	

BUREAU V. 3

APR 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrs. 29days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 1122 Hollins Street			
3. NAME OF DECEASED (Type or print) First William Middle Last Moon				4. DATE OF DEATH Month April Day 20 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1874	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Machinist		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Moon				14. MOTHER'S MAIDEN NAME Frances ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Infarction of occipital lobes of brain</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to arteriosclerosis, Pulmonary edema</p> <p>(c) Chronic Nephrosclerosis, Chr. Bronchitis</p> </div> <div style="width: 50%;"> <p>INTERVAL BETWEEN ONSET AND DEATH </p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Salivary gland hemorrhage of right side face</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George S. M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-21-56	
EXAMINER'S NAME (Type) George S. M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Ritchie Highway Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE KRAUSE FUNERAL HOME 1216 S. Charles St.				24a. REC'D BY REGISTRAR DATE APR 27 1956		24b. REGISTRAR'S SIGNATURE V. E. Harrys	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 3723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY OR TOWNSHIP	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
BACTERIOLOGICAL FINDINGS		CHEMICAL FINDINGS	
RADIOLOGICAL FINDINGS		OTHER FINDINGS	
FINAL DIAGNOSIS		REMARKS	

BUREAU V. S.

APR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3783

CERTIFICATE OF DEATH

03749

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Co.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SPRING GROVE STATE HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Wilhelmina Moselsy</i>		4. DATE OF DEATH <i>April 28 1956</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7.26.1873</i>	
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>John Moselsy</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT <i>medical Record.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General arteriosclerosis</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>2 or 3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>APRIL 4</i> , 19____, to <i>April 28</i> , 19____, that I last saw the deceased alive on <i>April 28</i> , 19____, and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>D. P. Davis</i>		DATE SIGNED		
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF <i>5/1/56</i>		
22c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Brooklyn Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles P. Hill</i>		ADDRESS <i>1501 E. Federal</i>		
24a. REC'D BY REGISTRAR DATE <i>5/1/56</i>		24b. REGISTRAR'S SIGNATURE <i>V. E. Harry</i>		

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>May 1, 1955</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL <i>Yes</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
19. SIGNATURE OF REGISTRAR <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
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100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

RECEIVED
MAY 2 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03750

3784

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd.</u>		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u> STREET ADDRESS (If rural, give location) <u>Glenarm Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Eustachia Muench</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>April 28 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 5, 1867</u>	9. AGE last birthday <u>89</u> yrs.	If under 1 year Months Days Hours Mins. <u>89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS.</u>		11. BIRTHPLACE (State or foreign country) <u>Newark N. J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Muench</u>		14. MOTHER'S MAIDEN NAME <u>Kana Grotzer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Thrombosis</u>		<u>3 days</u>
Antecedent cause(s) (b) <u>Bed-ridden 3 yrs. infirmity of old age</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 9, 1952, to April 28, 1956, that I last saw the deceased alive on Feb. 7, 1956, and that death occurred at 9:00 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>5-1-56</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/30/56</u>	<u>Rev. Hedrick</u>	<u>Charles S. Geier</u>	<u>901 S. CONKLING ST. BALTO., MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

03751

3785

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
TOWN <u>Overlea</u> LENGTH OF STAY (In this place) <u>36 yrs.</u>		TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4303 Belmar Ave.</u>		STREET ADDRESS (If rural, give location) <u>4303 Belmar Ave.</u>	
3. NAME OF DECEASED (First) <u>Helen</u> (Middle) <u>Marie</u> (Last) <u>Naegele</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>4</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>2 Sept 03</u>
9. AGE last birthday <u>52</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> If under 24 hrs: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Collier</u>		14. MOTHER'S MAIDEN NAME <u>Lavenia B. Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Joseph A. Naegele - 4803 Belmar Ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Carbon Monoxide Poisoning</u>		<u>1 day</u>
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Depressive Psychosis</u>		<u>3-4 yrs.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE John C. Kyle M.D. Hgt. Med. Ex. (Degree or title) ADDRESS 7527 Belair Rd DATE SIGNED 4-4-56

23. BURIAL, CREMATION REMEDIAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 7, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	LOCATION (City, town, or county) <u>Baltimore, Md</u> (State)
DATE REC'D BY LOCAL REG. <u>April 5, 1956</u>	REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Lanahan Funeral Home</u>	ADDRESS <u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

carbon monoxide suffocated - running car in closed garage.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03752

3786

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines Fusting Ave.		d. STREET ADDRESS 906 Walnut Ave.	
3. NAME OF DECEASED (Type or print) ANNIE M. NELSON		4. DATE OF DEATH April 26, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1875
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Wode		14. MOTHER'S MAIDEN NAME Caroline Alcock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. A. L. Bobbitt - 602 Walnut Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage DUE TO (b) Jangren, right leg DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1953 , to April 26, 1956 , that I last saw the deceased alive on April 25, 1956 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE D. C. MacLaughlin M.D.		ADDRESS (Street, city or town, state) 4508 Edmondson Village DATE SIGNED	
PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/56	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schenker & Sons - Balt.		24. REG. BY REGISTRAR W. E. Harvey	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. DEATH DATE		8. DEATH TIME		9. DEATH PLACE	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. PLACE OF INTERMENT	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF CORONER	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF CLERK		24. SIGNATURE OF RECTOR	
25. SIGNATURE OF CHURCH WARDEN		26. SIGNATURE OF MINISTER		27. SIGNATURE OF DEACON	
28. SIGNATURE OF ELDER		29. SIGNATURE OF SUNDAY SCHOOL TEACHER		30. SIGNATURE OF YOUTH LEADER	
31. SIGNATURE OF YOUTH COUNCILOR		32. SIGNATURE OF YOUTH LEADER		33. SIGNATURE OF YOUTH COUNCILOR	
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100. SIGNATURE OF YOUTH COUNCILOR		101. SIGNATURE OF YOUTH COUNCILOR		102. SIGNATURE OF YOUTH COUNCILOR	

RECEIVED
MAY 1 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03753

40

1. PLACE OF DEATH a. COUNTY <u>Fork Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>HAROLD A. NEVEL</u>		4. DATE OF DEATH <u>April 23 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1904</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, (yes) if retired)		9. AGE (In years last birthday) <u>48</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Jesse Nevel</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Cooney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hazel E. Nevel</u>		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>55</u> , to <u>4/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>56</u> , and that death occurred at <u>3:55</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		ADDRESS (Street, city or town, state) <u>Fork Md.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		DATE SIGNED <u>4/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 25 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lanahan Funeral Home</u>		24. REC'D BY REGISTRAR <u>Dr. Walter Hammett</u>	
ADDRESS <u>7401 Belair Rd.</u>		DATE <u>APR 25 1956</u>	

CERTIFICATE OF DEATH

Form 10-55

1. NAME OF DECEASED HAROLD A. NEVEL		2. SEX Male		3. AGE 44	
4. DATE OF DEATH April 25, 1956		5. TIME OF DEATH 1:15 PM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH New York	
10. OCCUPATION Salesman		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. MEDICAL HISTORY None		15. PHYSICIAN Dr. J. H. Smith	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF CLERK		21. SIGNATURE OF CHIEF OF BUREAU	

BUREAU V. S.

APR 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03754

3788

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Spring Grove State Hospital</u>		d. STREET ADDRESS <u>109 Church Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Dr. Elijah Emora Nichols</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Mariah Jane Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, left paraplegia</u> DUE TO (c) <u>Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Swollen feet, decubitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-24</u> , 19 <u>56</u> , to <u>4-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>56</u> , and that death occurred at <u>2:50 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Stella Wachler</u>		M.D. <u>Spring Grove State Hospital</u> <u>4-6-56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M.D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-9-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>F. E. Lantz</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE CITY CLERK	

BUREAU V. A.

APR 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3671

CERTIFICATE OF DEATH

03755 47

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MD. c. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4606 Leeds Ave		d. STREET ADDRESS 4606 Leeds Ave	
3. NAME OF DECEASED (Type or print) William Frederick Niepraschk		4. DATE OF DEATH Apr. 27, 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1890
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PBX Installer		10b. KIND OF BUSINESS OR INDUSTRY C & P Telephone	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gustav Niepraschk		14. MOTHER'S MAIDEN NAME Elizabeth Frank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-6832	
17. INFORMANT Mamie Niepraschk, 4606 Leeds Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema - Bilateral		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 11, 1956 to April 27, 1956 , that I last saw the deceased alive on April 11, 1956 , and that death occurred at 3 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE EARL PASS, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4001 Wilkens Ave 4-29-56	
PHYSICIAN'S NAME (Type) EARL PASS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-30-56	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR MAY 1 1956		24b. REGISTRAR'S SIGNATURE Dr. G. M. Kupper	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3271

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>May 1, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>	
10. SIGNATURE OF DECEASED <i>John A. Smith</i>		11. SIGNATURE OF WITNESS <i>John A. Smith</i>		12. SIGNATURE OF DECEASED <i>John A. Smith</i>	
13. SIGNATURE OF DECEASED <i>John A. Smith</i>		14. SIGNATURE OF DECEASED <i>John A. Smith</i>		15. SIGNATURE OF DECEASED <i>John A. Smith</i>	
16. SIGNATURE OF DECEASED <i>John A. Smith</i>		17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF DECEASED <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>		21. SIGNATURE OF DECEASED <i>John A. Smith</i>	
22. SIGNATURE OF DECEASED <i>John A. Smith</i>		23. SIGNATURE OF DECEASED <i>John A. Smith</i>		24. SIGNATURE OF DECEASED <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF DECEASED <i>John A. Smith</i>		27. SIGNATURE OF DECEASED <i>John A. Smith</i>	
28. SIGNATURE OF DECEASED <i>John A. Smith</i>		29. SIGNATURE OF DECEASED <i>John A. Smith</i>		30. SIGNATURE OF DECEASED <i>John A. Smith</i>	
31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF DECEASED <i>John A. Smith</i>		33. SIGNATURE OF DECEASED <i>John A. Smith</i>	
34. SIGNATURE OF DECEASED <i>John A. Smith</i>		35. SIGNATURE OF DECEASED <i>John A. Smith</i>		36. SIGNATURE OF DECEASED <i>John A. Smith</i>	
37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF DECEASED <i>John A. Smith</i>		39. SIGNATURE OF DECEASED <i>John A. Smith</i>	
40. SIGNATURE OF DECEASED <i>John A. Smith</i>		41. SIGNATURE OF DECEASED <i>John A. Smith</i>		42. SIGNATURE OF DECEASED <i>John A. Smith</i>	
43. SIGNATURE OF DECEASED <i>John A. Smith</i>		44. SIGNATURE OF DECEASED <i>John A. Smith</i>		45. SIGNATURE OF DECEASED <i>John A. Smith</i>	
46. SIGNATURE OF DECEASED <i>John A. Smith</i>		47. SIGNATURE OF DECEASED <i>John A. Smith</i>		48. SIGNATURE OF DECEASED <i>John A. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF DECEASED <i>John A. Smith</i>		51. SIGNATURE OF DECEASED <i>John A. Smith</i>	
52. SIGNATURE OF DECEASED <i>John A. Smith</i>		53. SIGNATURE OF DECEASED <i>John A. Smith</i>		54. SIGNATURE OF DECEASED <i>John A. Smith</i>	
55. SIGNATURE OF DECEASED <i>John A. Smith</i>		56. SIGNATURE OF DECEASED <i>John A. Smith</i>		57. SIGNATURE OF DECEASED <i>John A. Smith</i>	
58. SIGNATURE OF DECEASED <i>John A. Smith</i>		59. SIGNATURE OF DECEASED <i>John A. Smith</i>		60. SIGNATURE OF DECEASED <i>John A. Smith</i>	
61. SIGNATURE OF DECEASED <i>John A. Smith</i>		62. SIGNATURE OF DECEASED <i>John A. Smith</i>		63. SIGNATURE OF DECEASED <i>John A. Smith</i>	
64. SIGNATURE OF DECEASED <i>John A. Smith</i>		65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF DECEASED <i>John A. Smith</i>	
67. SIGNATURE OF DECEASED <i>John A. Smith</i>		68. SIGNATURE OF DECEASED <i>John A. Smith</i>		69. SIGNATURE OF DECEASED <i>John A. Smith</i>	
70. SIGNATURE OF DECEASED <i>John A. Smith</i>		71. SIGNATURE OF DECEASED <i>John A. Smith</i>		72. SIGNATURE OF DECEASED <i>John A. Smith</i>	
73. SIGNATURE OF DECEASED <i>John A. Smith</i>		74. SIGNATURE OF DECEASED <i>John A. Smith</i>		75. SIGNATURE OF DECEASED <i>John A. Smith</i>	
76. SIGNATURE OF DECEASED <i>John A. Smith</i>		77. SIGNATURE OF DECEASED <i>John A. Smith</i>		78. SIGNATURE OF DECEASED <i>John A. Smith</i>	
79. SIGNATURE OF DECEASED <i>John A. Smith</i>		80. SIGNATURE OF DECEASED <i>John A. Smith</i>		81. SIGNATURE OF DECEASED <i>John A. Smith</i>	
82. SIGNATURE OF DECEASED <i>John A. Smith</i>		83. SIGNATURE OF DECEASED <i>John A. Smith</i>		84. SIGNATURE OF DECEASED <i>John A. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF DECEASED <i>John A. Smith</i>		87. SIGNATURE OF DECEASED <i>John A. Smith</i>	
88. SIGNATURE OF DECEASED <i>John A. Smith</i>		89. SIGNATURE OF DECEASED <i>John A. Smith</i>		90. SIGNATURE OF DECEASED <i>John A. Smith</i>	
91. SIGNATURE OF DECEASED <i>John A. Smith</i>		92. SIGNATURE OF DECEASED <i>John A. Smith</i>		93. SIGNATURE OF DECEASED <i>John A. Smith</i>	
94. SIGNATURE OF DECEASED <i>John A. Smith</i>		95. SIGNATURE OF DECEASED <i>John A. Smith</i>		96. SIGNATURE OF DECEASED <i>John A. Smith</i>	
97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF DECEASED <i>John A. Smith</i>		99. SIGNATURE OF DECEASED <i>John A. Smith</i>	
100. SIGNATURE OF DECEASED <i>John A. Smith</i>		101. SIGNATURE OF DECEASED <i>John A. Smith</i>		102. SIGNATURE OF DECEASED <i>John A. Smith</i>	

BUREAU V. S.

MAY 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03756 3789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville 28			c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701-4 ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Spring Grove State Hospital				d. STREET ADDRESS 27 N. Carey Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle NMI Last Obst				4. DATE OF DEATH Month April Day 1 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 14, 1881		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Wallace Jones				14. MOTHER'S MAIDEN NAME Kate KENSEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 219-14-0399A		17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4-4-56		22c. NAME OF CEMETERY OR CREMATORY MT OLIVET	
22d. LOCATION (City, town, or county) (State) 2930 FREDERICK AVE							
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight Inc				ADDRESS 6009 Hayford Rd		24a. REC'D BY REGISTRAR DATE 4/3/56	
24b. REGISTRAR'S SIGNATURE T. E. Harris							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case examiner should execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
 3722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>James Thomas</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>April 1, 1956</i>		PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>1234 Main St, Baltimore, Md</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		SIGNATURE OF EXAMINER <i>[Signature]</i>		DATE OF EXAMINATION <i>April 1, 1956</i>	
FAMILY HISTORY <i>None</i>		PREVIOUS ILLNESS <i>None</i>		SIGNS AND SYMPTOMS <i>None</i>		POST-MORTEM FINDINGS <i>None</i>		TESTS AND EXAMINATIONS <i>None</i>		REMARKS <i>None</i>	

BUREAU V. 1

APR 4 1956

RECEIVED

[Handwritten signature]
 GEO 211 (151-1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3790

CERTIFICATE OF DEATH

Reg. Dist. No.

0375733

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowings Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
c. LENGTH OF STAY IN 1b <u>3 yrs 6 mos</u>				d. STREET ADDRESS <u>2920 N Calvert-51</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tr Schol</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Edward O'Meara</u>				4. DATE OF DEATH <u>April 14 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>10/18/50</u>		9. AGE (In years lost birthday) <u>5</u> yrs.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Jerome T. O'Meara</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Welker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address <u>Hospital Records, Rosewood, Bowings Mills</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Failure of respiration, central</u> DUE TO <u>752X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Increased intracranial pressure</u> DUE TO (c) <u>Congenital hypertensive hydrocephalus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles L. Anala</u>				ADDRESS (Street, city or town, state) <u>2920 N. Calvert #18</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>April 17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>				ADDRESS <u>3818 Roland Ave</u>		24a. REC'D BY REGISTRAR <u>APR 16 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary Blinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3700

DEATH OF A NATURAL PERSON (For deaths occurring in the State of Maryland, whether or not the decedent was born in the State, and whether or not the decedent was a resident of the State at the time of death.)		DEATH OF A NON-NATURAL PERSON (For deaths occurring in the State of Maryland, whether or not the decedent was born in the State, and whether or not the decedent was a resident of the State at the time of death.)	
NAME OF DECEASED (Print or write full name, including middle name or initial, and last name.)		NAME OF DECEASED (Print or write full name, including middle name or initial, and last name.)	
SEX (Male or Female)		SEX (Male or Female)	
DATE OF BIRTH (Month, day, and year)		DATE OF BIRTH (Month, day, and year)	
PLACE OF BIRTH (City, State, and Country)		PLACE OF BIRTH (City, State, and Country)	
USUAL RESIDENCE (City, State, and Country)		USUAL RESIDENCE (City, State, and Country)	
OCCUPATION (Print or write occupation)		OCCUPATION (Print or write occupation)	
CAUSE OF DEATH (Print or write cause of death)		CAUSE OF DEATH (Print or write cause of death)	
MANNER OF DEATH (Print or write manner of death)		MANNER OF DEATH (Print or write manner of death)	
DATE OF DEATH (Month, day, and year)		DATE OF DEATH (Month, day, and year)	
PLACE OF DEATH (City, State, and Country)		PLACE OF DEATH (City, State, and Country)	
SIGNATURE OF DECEASED (Print or write signature)		SIGNATURE OF DECEASED (Print or write signature)	
SIGNATURE OF WITNESS (Print or write signature)		SIGNATURE OF WITNESS (Print or write signature)	
SIGNATURE OF PHYSICIAN (Print or write signature)		SIGNATURE OF PHYSICIAN (Print or write signature)	
SIGNATURE OF CORONER (Print or write signature)		SIGNATURE OF CORONER (Print or write signature)	
SIGNATURE OF JUDGE (Print or write signature)		SIGNATURE OF JUDGE (Print or write signature)	
SIGNATURE OF CLERK (Print or write signature)		SIGNATURE OF CLERK (Print or write signature)	

BUREAU V. S.

APR 16 1956

RECEIVED

3700

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03758
44

3791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 11 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VALENTINE Middle J. Last PALASIK				4. DATE OF DEATH Month April Day 7 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-11		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER				10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME VALENTINE PALASIK				14. MOTHER'S MAIDEN NAME BARBARA NOVAK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FORT HOWARD, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMATEMESIS 581.0 DUE TO ESOPHAGEAL VARICES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO CIRRHOSIS OF LIVER (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATIC HEART DISEASE WITH MITRAL INVOLVEMENT * DURATION UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from March 27 , 1956, to April 7 , 1956, and that death occurred at 6:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John A. Surmonte</i> PHYSICIAN'S NAME (Type) John A. Surmonte, M.D.				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 4-7-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/56		22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE 22, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William S. Fialkowski</i> William S. Fialkowski Funeral Home				24a. REC'D BY REGISTRAR APR 9 1956 DATE			
24b. REGISTRAR'S SIGNATURE <i>Sharon L. Fisher</i>							

2007 Eastern Ave., Baltimore 31, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2791

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1900		BALTIMORE, MD.		JAN 15 1956		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
MARRIED		JAN 15 1920		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1920		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1920	
EDUCATION		SCHOOL		DEGREE		DATE		PLACE		NAME		DATE		PLACE	
HIGH SCHOOL		BALTIMORE, MD.		B.S.		JAN 15 1920		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1920		BALTIMORE, MD.	
OCCUPATION		BUSINESS		DATE		PLACE		NAME		DATE		PLACE		NAME	
BUSINESS		JAN 15 1920		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1920		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1920	
CAUSE OF DEATH		HEART		DATE		PLACE		NAME		DATE		PLACE		NAME	
HEART		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956	
MANNER OF DEATH		NATURAL		DATE		PLACE		NAME		DATE		PLACE		NAME	
NATURAL		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956	
SIGNATURE OF DECEASED		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956	
SIGNATURE OF WITNESS		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956	
SIGNATURE OF CORONER		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1956	

BUREAU V. 3

APR 10 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3792

Reg. Dist. No.

03759-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>White Hall Rd.</u>		d. STREET ADDRESS <u>White Hall Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Pearce</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 30, 1881</u> 74 yrs.
9. AGE (In years less birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph W. Pearce</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Lytle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Name <u>Mrs. Alice Pearce</u> Address <u>White Hall Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR</u> <u>442X</u> DUE TO <u>RENAL DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN.</u> , 19 <u>53</u> , to <u>APRIL 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>APRIL 18</u> , 19 <u>56</u> , and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lloyd E. Saylor</u>		DATE SIGNED <u>3902 GREENMOUNT AVE.</u>	
PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor</u>		<u>BALTIMORE-18 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 21, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		24. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	

BUREAU V. S.

APR 24 1956

RECEIVED

3793

03761

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	LENGTH OF STAY (In this place) <i>8 weeks</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>R. J. E. 4</i>	<i>06X-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Berryman Lane Reisterstown</i>		STREET ADDRESS (If rural, give location) <i>Manchester Road</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Hubert</i>	(Middle) <i>—</i>	(Last) <i>Poff</i>	(Month) <i>April</i> (Day) <i>24</i> (Year) <i>1956</i>
5. SEX: <i>m.</i>	6. COLOR OR RACE: <i>w.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>Feb. 6, 1932</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Farm manager</i>	9. AGE last birthday: <i>24</i> yrs.
13. FATHER'S NAME: <i>Posey Poff</i>		14. MOTHER'S MAIDEN NAME: <i>Era Puckett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no.</i>		16. SOCIAL SECURITY No.: <i>215-26-1181</i>	
17. INFORMANT & ADDRESS: <i>Clayton W. Poff, Hampstead md</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <i>Crushed sternum, back & upper left chest</i> DUE TO <i>with internal hemorrhage & asphyxia</i>		<i>50 min.?</i>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <i>none</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDING OF OPERATION: <i>none</i>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <i>Larkin's farm</i>	
21c. (City or town) (County) (State) <i>Reisterstown Balto. Md.</i>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>4-24-56 348 P. M.</i>	
21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Deceased backed tractor under overhang of barn & was crushed up against steering wheel</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>J. D. Caples</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>4-26-56</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>April 27, 56</i>	
NAME OF CEMETERY OR CREMATORY <i>Piney Grove Cemetery</i>		LOCATION (City, town, or county) (State) <i>Mount Airy md.</i>	
DATE REC'D BY LOCAL REG. <i>4-26-56</i>		24. FUNERAL DIRECTOR <i>Wm. Berryman & Sons Reisterstown md</i>	
REGISTRAR'S SIGNATURE <i>Mary B. Shive</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 27 1956

RECEIVED

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3794

CERTIFICATE OF DEATH

03762

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>7 Days</u>		d. STREET ADDRESS <u>115 N. Clinton Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLINTON</u> Middle <u>M</u> Last <u>POWELL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1897</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilhost, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin L. Powell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>213-05-2666</u>	
17. INFORMANT <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 29, 1956</u> , to <u>April 5, 1956</u> , that I last saw the deceased <u>alive on March 29, 1956</u> and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis G. Dickey</u> M.D.		ADDRESS (Street, city or town, state) <u>VAH Ft. Howard, Maryland</u> DATE SIGNED <u>4/5/56</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY</u>		VAH Ft. Howard, Maryland <u>4/5/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 9, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Zeiler, Inc.</u>		ADDRESS <u>Eastern & Wolfe St. Balto. Md.</u>	
24a. REC'D BY REGISTRAR <u>April 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. W. Dawson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3795

CERTIFICATE OF DEATH

03763

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY <u>BALTIMORE</u>		TOWN <u>SPARKS</u>	
CITY OR TOWN <u>TEXAS COCKLEVILLE</u>		LENGTH OF STAY (in this place) <u>1 mo. 19 DAY</u>		STREET ADDRESS <u>BALTIMORE COUNTY HOME</u>		(If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES HENRY POWELL</u>				4. DATE OF DEATH (Month) <u>APR</u> (Day) <u>15</u> (Year) <u>19 56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>?</u>	9. AGE last birthday <u>about 58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORFOLK VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES POWELL</u>				14. MOTHER'S MAIDEN NAME <u>MARY WEST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-32-9607A</u>		17. INFORMANT & ADDRESS <u>JOHN MOSBY SPARKS, Ind</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						years. <u>✓</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u>, 19<u>53</u>, to <u>April 14</u>, 19<u>56</u>, that I last saw the deceased alive on <u>April 14</u>, 19<u>56</u>, and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elicabith B. Hurrell</u>		M.D. <u>Cockeysville, Md.</u>		DATE SIGNED <u>4/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/19/56</u>		NAME OF CEMETERY, OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Balt., Md.</u>	
24. REC'D BY REGISTRAR <u>4/19/56</u>		REGISTRAR'S SIGNATURE <u>Mrs. J. H. Hurrell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chalmers - 1701 McCulloch</u>		ADDRESS <u>Balt., Md.</u>	

2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

BUREAU V. S.

APR 18 1956

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3796

CERTIFICATE OF DEATH

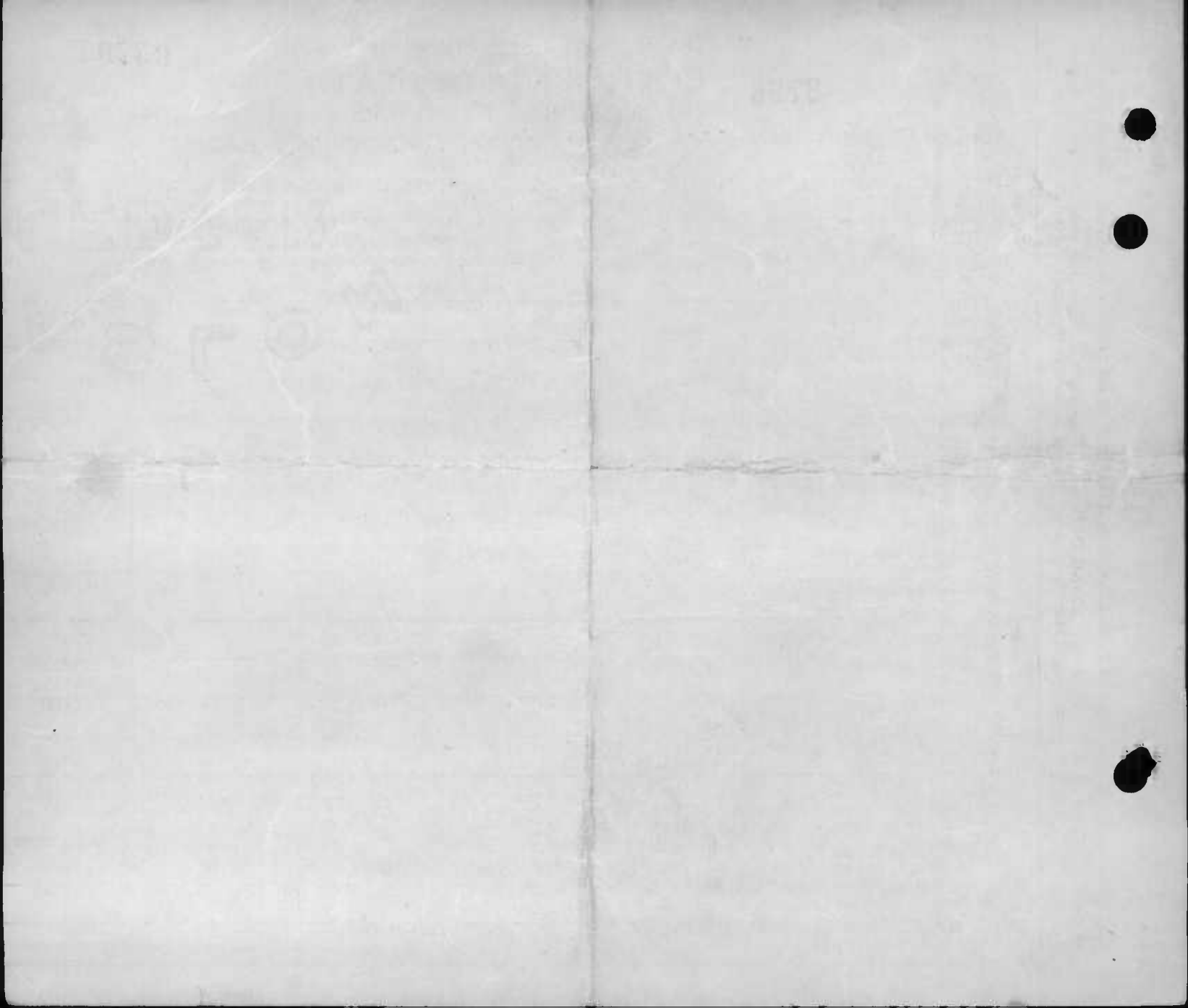
FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>818 Shuter St. Balto Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fullerton Md.</u>		STREET ADDRESS (If rural, give location) <u>818 Shuter St</u> 3V014	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Robert</u> <u>Proctor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4</u> <u>16</u> <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec 11, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Abraham Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Hester Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Clara Dixon 9377 Dallas St</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Thrombosis</u> Antecedent cause(s) (b) <u>Generalized Atherosclerosis</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Instantly</u> <u>Under</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion, resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>John C. Mc</u>		ADDRESS <u>Mt. Hope, 7527 Belair Rd</u> DATE SIGNED <u>4/16/56</u>	
23. METHOD OF CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 10/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		LOCATION (City, town, or county) (State) <u>A. C. County Md.</u>	
DATE REC'D BY LOCAL REG. <u>9 56</u>		REGISTRAR'S SIGNATURE <u>Dr. H. H. H.</u>	
24. FUNERAL DIRECTOR <u>Mrs. Robert A. Elliott & Daughter</u>		ADDRESS <u>1129 N. Caroline St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03765

3797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN TB 2yr11mos5days					
d. NAME OF HOSPITAL (If not in hospital, give street address) 14 Spring Grove State Hospital				d. STREET ADDRESS 734 W. North Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED First Middle Last Charles D. Provonche, Sr.				4. DATE OF DEATH Month Day Year April 2, 19 56					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown 1-29-1888			
9. AGE (In years last birthday) 68? yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engineer				10b. KIND OF BUSINESS OR INDUSTRY MD. CASUALTY CO.					
11. BIRTHPLACE (State or foreign country) Unknown WISCONSIN				12. CITIZEN OF WHAT COUNTRY? Unknown U.S.A.					
13. FATHER'S NAME Unknown CHARLES C. PROVONCHE				14. MOTHER'S MAIDEN NAME Unknown ANNA Z. GILLETTE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown 1-29-1888-10-19-1944				16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT Records Spring Grove State Hospital				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 490x DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Brain Disease Years								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Spring Grove State Hospital				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from 4-28- 19 53 , to 4-2- 19 56 , that I last saw the deceased alive on April 2, 19 56 , and that death occurred at 7:47 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4/2/56									
ACTUAL SIGNATURE Joseph R. Cowen				M.D. Spring Grove State Hospital					
PHYSICIAN'S NAME (Type) Joseph R. Cowen, M. D.				Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-6-1956		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) FORT MEYER, VA.			
23. FUNERAL DIRECTOR'S SIGNATURE John P. Hyatt				ADDRESS 3444 BELAIR RD.		24a. REC'D BY REGISTRAR Conklin J. W.			
				DATE 1956		24b. REGISTRAR'S SIGNATURE W. E. Hays			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. DATE OF DEATH [Illegible]		11. PLACE OF DEATH [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF PHYSICIAN [Illegible]		15. SIGNATURE OF CORONER [Illegible]	
16. SIGNATURE OF JURY [Illegible]		17. SIGNATURE OF JUDGE [Illegible]		18. SIGNATURE OF CLERK [Illegible]	
19. SIGNATURE OF [Illegible] [Illegible]		20. SIGNATURE OF [Illegible] [Illegible]		21. SIGNATURE OF [Illegible] [Illegible]	
22. SIGNATURE OF [Illegible] [Illegible]		23. SIGNATURE OF [Illegible] [Illegible]		24. SIGNATURE OF [Illegible] [Illegible]	
25. SIGNATURE OF [Illegible] [Illegible]		26. SIGNATURE OF [Illegible] [Illegible]		27. SIGNATURE OF [Illegible] [Illegible]	
28. SIGNATURE OF [Illegible] [Illegible]		29. SIGNATURE OF [Illegible] [Illegible]		30. SIGNATURE OF [Illegible] [Illegible]	
31. SIGNATURE OF [Illegible] [Illegible]		32. SIGNATURE OF [Illegible] [Illegible]		33. SIGNATURE OF [Illegible] [Illegible]	
34. SIGNATURE OF [Illegible] [Illegible]		35. SIGNATURE OF [Illegible] [Illegible]		36. SIGNATURE OF [Illegible] [Illegible]	
37. SIGNATURE OF [Illegible] [Illegible]		38. SIGNATURE OF [Illegible] [Illegible]		39. SIGNATURE OF [Illegible] [Illegible]	
40. SIGNATURE OF [Illegible] [Illegible]		41. SIGNATURE OF [Illegible] [Illegible]		42. SIGNATURE OF [Illegible] [Illegible]	
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70. SIGNATURE OF [Illegible] [Illegible]		71. SIGNATURE OF [Illegible] [Illegible]		72. SIGNATURE OF [Illegible] [Illegible]	
73. SIGNATURE OF [Illegible] [Illegible]		74. SIGNATURE OF [Illegible] [Illegible]		75. SIGNATURE OF [Illegible] [Illegible]	
76. SIGNATURE OF [Illegible] [Illegible]		77. SIGNATURE OF [Illegible] [Illegible]		78. SIGNATURE OF [Illegible] [Illegible]	
79. SIGNATURE OF [Illegible] [Illegible]		80. SIGNATURE OF [Illegible] [Illegible]		81. SIGNATURE OF [Illegible] [Illegible]	
82. SIGNATURE OF [Illegible] [Illegible]		83. SIGNATURE OF [Illegible] [Illegible]		84. SIGNATURE OF [Illegible] [Illegible]	
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91. SIGNATURE OF [Illegible] [Illegible]		92. SIGNATURE OF [Illegible] [Illegible]		93. SIGNATURE OF [Illegible] [Illegible]	
94. SIGNATURE OF [Illegible] [Illegible]		95. SIGNATURE OF [Illegible] [Illegible]		96. SIGNATURE OF [Illegible] [Illegible]	
97. SIGNATURE OF [Illegible] [Illegible]		98. SIGNATURE OF [Illegible] [Illegible]		99. SIGNATURE OF [Illegible] [Illegible]	
100. SIGNATURE OF [Illegible] [Illegible]		101. SIGNATURE OF [Illegible] [Illegible]		102. SIGNATURE OF [Illegible] [Illegible]	

BUREAU V. S.

APR 5 1956

RECEIVED

Vertical text on the right edge of the page, likely a filing or processing stamp.

3798

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Julie</u>				d. STREET ADDRESS <u>Valley Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Sister Augustine Julie (Quinn)</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1893</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Quinn</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Quinn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>0----</u>		17. INFORMANT Address <u>Sister Marie Dolores Villa Julie</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis with Pulmonary Emphsema</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio - Renal vascular disease</u> DUE TO (c) <u>Staph - aurio hemolytic abcess - base of spine</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>6 years</u> <u>72 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>56</u> , to <u>April 21, 1956</u> , that I last saw the deceased alive on <u>April 21, 1956</u> , and that death occurred at <u>8:15 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold H Burns</u>				ADDRESS (Street, city or town, state) <u>115 E. Eager St.</u>		DATE SIGNED <u>4/23/56</u>	
PHYSICIAN'S NAME (Type) <u>Harold H. Burns, M.D.</u>				<u>Baltimore 2, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Ilchester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>For My Funeral Home - Catonsville, Md.</u>				24. REC'D BY REGISTRAR DATE <u>APR 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Miss Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 037670

3799

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b LIFETIME		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURSING HOME		d. STREET ADDRESS 42 S. CAROLTON AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John J Rabe		4. DATE OF DEATH Month 4 Day 12 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-1873
9. AGE (In years for birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY BANK	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Rabe		14. MOTHER'S MAIDEN NAME Agnes Eiche LMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-090998	
17. INFORMANT Fred Herbert Address 42 S. CAROLTON AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis. Generalized arteriosclerosis. (c) STATUS POST CEREBROVASCULAR ACCIDENT		INTERVAL BETWEEN ONSET AND DEATH minutes year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 11 , 19 56 , to April 12 , 19 56 , that I last saw the deceased alive on April 11 , 19 56 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry Armanas M.D.		DATE SIGNED 4-14-56	
PHYSICIAN'S NAME (Type) HENRY ARMANAS		Baltimore 23, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-16-1956	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD		22d. LOCATION (City, town, or county) (State) BALTIMORE Md	
23. FUNERAL DIRECTOR'S SIGNATURE Chas F. Evans & Son ADDRESS 118 W. MT. ROYAL AVE.		24a. REC'D BY REGISTRAR 4/14/56 24b. REGISTRAR'S SIGNATURE R. E. Lang	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3870

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8601 Richmond Circle				d. STREET ADDRESS 8601 Richmond Circle			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mrs. Middle Cora Last M. Reeves				4. DATE OF DEATH Month April Day 19 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Hoard				14. MOTHER'S MAIDEN NAME Nancy Dodge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Albert M. Reeves, 8601 Richmond Circle			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9 DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Small bladder disease (c) 6 mo PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1954 , 19____, to Apr 19 , 19____, that I last saw the deceased alive on Apr 17 , 19____, and that death occurred at 3 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED PRITZ & KIMZEY M.D. Apr 19 1956							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) PRITZ & KIMZEY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/1956		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Marford Road #14				24. REC'D BY REGISTRAR APR 20 1956			
				24b. REGISTRAR'S SIGNATURE Dr. A. M. Beatty			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03769

CERTIFICATE OF DEATH

Reg. Dist. No.

3871

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	c. LENGTH OF STAY IN 1b <u>2 month 4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u> <u>16 X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Spring Grove State Hospital</u>		d. STREET ADDRESS <u>3402-39th Place</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>R</u> Last <u>Reeves</u>	4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1885</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George C. Reeves</u>		14. MOTHER'S MAIDEN NAME <u>Ida M. Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Elizabeth Reeves</u> Address <u>3402-39th Place Colmar Manor</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cerebro vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arterio sclerotic cardiovascular disease</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/17</u> , 19 <u>56</u> , to <u>4/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/21/56</u> , 19 <u>56</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslor</u>		DATE SIGNED <u>4/21/56</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		<u>CATONSVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-24-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. GASCH SON'S</u>		24a. REC'D BY REGISTRAR <u>APR 27 1956</u>	
ADDRESS <u>HYATTSVILLE, MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>A. J. B. Bonyo</u>	

BUREAU V. S.

APR 27 1956

RECEIVED

3802

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>			
c. LENGTH OF STAY IN 1b <u>life</u>				d. STREET ADDRESS <u>same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 Meadowbrook One</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Peter M. Reitz</u> First Middle Last				4. DATE OF DEATH <u>Apr 29</u> Month Day Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1869</u> yrs. <u>86</u>	
9. AGE (In years, say birthday) <u>86</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. Reitz</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT <u>Mrs Eva Mossberger</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decomposition</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vasc. Renal Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>15 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Oct. 10</u> , 1953, to <u>April 29</u> , 1956, that I last saw the deceased alive on <u>April 28</u> , 1956, and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer R. Gallagher</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer R. Gallagher</u>				DATE SIGNED <u>Baltimore-28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 1, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nab + Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR <u>DATE 5/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>T.E. Harvey</u>	

MEDICAL CERTIFICATION

CATONSVILLE 28, MARYLAND

FREDERICK AND WADE AVENUES

MACNABB FUNERAL HOME

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. 2

MAY 7 1956

RECEIVED

58

CERTIFICATE OF DEATH

03771

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

Page 4

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES WILSON		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1890	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer	
7. MARITAL STATUS Married		8. EDUCATION High School	
9. RELIGION Methodist		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. PLACE OF DEATH Home		14. DATE OF DEATH April 6, 1956	
15. SIGNATURE OF PHYSICIAN J. W. Smith		16. SIGNATURE OF REGISTRAR J. W. Smith	
17. SIGNATURE OF DECEASED J. W. Smith		18. SIGNATURE OF WITNESSES J. W. Smith	
19. SIGNATURE OF FUNERAL HOME J. W. Smith		20. SIGNATURE OF CLERGYMAN J. W. Smith	
21. SIGNATURE OF BURIAL PLACE J. W. Smith		22. SIGNATURE OF INTERVIEWER J. W. Smith	
23. SIGNATURE OF COUNTY CLERK J. W. Smith		24. SIGNATURE OF STATE CLERK J. W. Smith	

BUREAU V. 2

APR 6 1956

RECEIVED

03773

Reg. Dist. No. 30

4. Jacob Martindale, New Freedom, Va. DATE 4/13/56 Rehearsal & Practice

VS. A15ME(5)
SM 9/55

BUREAU V. S.

APR 17 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 715 Millen Road		d. STREET ADDRESS 4110 Northern Parkway	
3. NAME OF DECEASED (Type or print) Mr. Harry Clermont Rivers Sr		4. DATE OF DEATH April 12 1956	
5. SEX male c	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1882
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Tareytown, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Rivers		14. MOTHER'S MAIDEN NAME Elizabeth Stevenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna R. Sommer, 715 Millen Road, #4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary artery disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from sept 19 1956 to april 12 1956 ; that I last saw the deceased alive on april 12 1956 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Marford Road #14		24a. REC'D BY REGISTRAR APR 16 1956 24b. REGISTRAR'S SIGNATURE Mabel Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3806 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03775

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex		c. LENGTH OF STAY IN lb 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 701 Eastern Blvd. Essex			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00				d. STREET ADDRESS 701 Eastern Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leslie Middle Robertson Last Robertson				4. DATE OF DEATH Month April Day 14 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1902	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 23 Days 23		IF UNDER 24 HRS. Hours 23 Min. 23			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Howard Robertson				14. MOTHER'S MAIDEN NAME Bessie Foutch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 217-10-7992		17. INFORMANT James Wm. Nolen		Address 701 Eastern Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Frederick Rd., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 418 Eastern Blvd. Essex				24a. REC'D BY REGISTRAR DATE 18 1956		24b. REGISTRAR'S SIGNATURE Mrs Edith Shirley	

BUREAU V. S.

APR 13 1956

RECEIVED
APR 13 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3807

CERTIFICATE OF DEATH

03776

Reg. Dist. No.

32

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Mt. Wilson State Hospital		d. STREET ADDRESS 12X-2	
3. NAME OF DECEASED (Type or print) First MERLE Middle H Last ROBINSON		4. DATE OF DEATH Month 4 Day 2 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.15.04
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) DARLINGTON, Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME HOWARD ROBINSON		14. MOTHER'S MAIDEN NAME ADA JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 216098923	
17. INFORMANT Hospital Records		Address Mt. Wilson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X FAR ADVANCED PULMONARY CAVITARY, TUBERCULOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3.23.1956 to 4.2.1956 , that I last saw the deceased alive on 4.2.1956 , and that death occurred at 2:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 4.2.56			
ACTUAL SIGNATURE William Newcomer M.D.		DATE SIGNED 4.2.56	
PHYSICIAN'S NAME (Type) WM. NEWCOMER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Harford Cem	22d. LOCATION (City, town, or county) (State) Harford Co, Md
23. FUNERAL DIRECTOR'S SIGNATURE H.S. Bailey ADDRESS Darlington, Md.		24a. REC'D BY REGISTRAR DR 10 1956 24b. REGISTRAR'S SIGNATURE W. K. Kirk	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3807

MARYLAND STATE DEPARTMENT OF HEALTH—BUREAU OF VITALS

DATE OF DEATH

DECEASED

DATE OF DEATH

Wilson

Wilson State Hospital

AGE

MALE

ROBINSON

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

APR 11 1956

PLACE OF DEATH

WILSON STATE HOSPITAL

BUREAU V. S.

APR 10 1956

RECEIVED

3828 CERTIFICATE OF DEATH

Items 13, 14 Film G196 4-20-56 et

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Maryland Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Edgemere</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write TOWN and give nearest town) <u>Edgemere</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2433 Brannon Ave.</u>				STREET ADDRESS (If rural give location) <u>2433 Brannon Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mollie T. Rotan</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>April 1, 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Nov. 27, 1876</u>	
				9. AGE last birthday: <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>? Wissussek</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.				16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Herbert F. Rotan 2433 Brannon Ave.</u>	
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X Immediate cause (a) <u>Cerebral Hemorrhage</u>							<u>5 days</u>
Antecedent causes (s) (b) <u>Hypertension C-V Disease</u>							<u>6 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April</u> , 19 <u>56</u> , and that death occurred at <u>10:07 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>James T. Means</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>520 20 St. Balt. 19 Md</u>		DATE SIGNED <u>4/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr. 3, 1956</u>		<u>Oak Lawn</u>		<u>Colgate, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>APR 5 1956</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Lark</u>		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 5 1956

RECEIVED

3809
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1105 Essex Rd. Cathering Robb Nursing Home				d. STREET ADDRESS 8807 Liberty Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMELIA Middle LOUISE Last RUSSELL				4. DATE OF DEATH Month April Day 30 , Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1869		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Glaser				14. MOTHER'S MAIDEN NAME Mary Piel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Frances R. Henry-7126 Dogwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILAT. LOBAR PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC FAILURE GR II DUE TO (c) ESSENTIAL HYPERTENSION						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR 9, 1956 , to APR 30, 1956 , that I last saw the deceased alive on APR 30, 1956 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) RANDALLSTOWN, MD. DATE SIGNED							
ACTUAL SIGNATURE [Signature]				M.D. RANDALLSTOWN, MD.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/56		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balt. 17 Md				24a. REC'D BY REGISTRAR DATE 5/2/56		24b. REGISTRAR'S SIGNATURE Mrs. Edith Shuleys	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1956

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

03779

Reg. Dist. No. 77

3666

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY BALTO	MARYLAND	CITY OR TOWN DUNDALK	COUNTY BALTO
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK	LENGTH OF STAY (in this place) 14 YRS	CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK	CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6900 SOLLERS PT. RD.		STREET ADDRESS 6900 SOLLERS PT. RD.	
3. NAME OF DECEASED (First) (Middle) (Last) ROY FRANKLIN SANDRIDGE, SR.		4. DATE OF DEATH (Month) (Day) (Year) 4-16-1956	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH APR. 16, 1912
9. AGE last birthday 44 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOADER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME ERNEST R. SANDRIDGE		14. MOTHER'S MAIDEN NAME LUCY WALTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) NO		16. SOCIAL SECURITY NO. 219-05-0096	
17. INFORMANT & ADDRESS EDNA V. SANDRIDGE - SAME			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Ca of Rectum Generalized Metastasis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19a. DATE OF OPERATION March 1956		19b. MAJOR FINDINGS OF OPERATION Same - Colon - 1955-	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 19, 1956, to April 16, 1956, that I last saw the deceased alive on April 16, 1956, and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
SIGNATURE M. B. Davis		ADDRESS (Street, city, town, state) M.D. 6800 Maryland - Dundalk - Md	
DATE SIGNED APR 20 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. DATE THEREOF 4-20-56	
25. NAME OF CEMETERY OR CREMATORY OAK LAWN		26. LOCATION (City, town, or county) (State) BALTO. CO. MD	
27. REC'D BY REGISTRAR APR 20 1956		28. REGISTRAR'S SIGNATURE M. M. Kelly	
29. FUNERAL DIRECTOR'S SIGNATURE M. M. Kelly		30. ADDRESS M. M. Kelly	

BUREAU V. S.

APR 20 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3810 CERTIFICATE OF DEATH

03780

Reg. Dist. No. 39

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Monkton</u>	LENGTH OF STAY (in this place) <u>25 yrs</u>	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Corbett Rd.</u>		STREET ADDRESS (If rural give location) <u>Rural - Monkton</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>George</u> (Middle) <u>Arthur</u> (Last) <u>Saportas</u>		(Month) <u>4</u> (Day) <u>14</u> (Year) <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>4-8-1904</u>
		9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>horse training</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>George A. Saportas</u>		14. MOTHER'S MARDEN NAME <u>Regina Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-22-7464</u>	
		17. INFORMANT & ADDRESS <u>Mrs. Mildred P. Saportas, Monkton, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>			<u>1 hr. ??</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug.</u> , 19 <u>54</u> , to <u>14 APR.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 APR.</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>Thos. A.E. Moreley</u>		DATE SIGNED <u>Jarrettsville, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4-16-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. James Episcopal</u>		LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4-17-56</u>		REGISTRAR'S SIGNATURE <u>M. Elizabeth Gersuch</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>	

CERTIFICATE OF DEATH

Reg. Gen. No.

1. Name of Deceased (Print or Write)

2. Sex (Male or Female)

3. Date of Birth (Month, Day, Year)

4. Place of Birth (City, State, Country)

5. Usual Residence (City, State, Country)

6. Date of Death (Month, Day, Year)

7. Time of Death (Hour, Minute)

8. Cause of Death (Print or Write)

9. Manner of Death (Print or Write)

10. Signature of Physician (Print or Write)

11. Signature of Registrar (Print or Write)

12. Signature of Coroner (Print or Write)

13. Signature of Medical Examiner (Print or Write)

14. Signature of Health Officer (Print or Write)

15. Signature of Other (Print or Write)

16. Signature of Other (Print or Write)

17. Signature of Other (Print or Write)

18. Signature of Other (Print or Write)

19. Signature of Other (Print or Write)

20. Signature of Other (Print or Write)

21. Signature of Other (Print or Write)

22. Signature of Other (Print or Write)

23. Signature of Other (Print or Write)

24. Signature of Other (Print or Write)

25. Signature of Other (Print or Write)

26. Signature of Other (Print or Write)

27. Signature of Other (Print or Write)

28. Signature of Other (Print or Write)

BUREAU V. S.

APR 18 1956

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1. Name of Deceased (Print or Write)
2. Sex (Male or Female)
3. Date of Birth (Month, Day, Year)
4. Place of Birth (City, State, Country)
5. Usual Residence (City, State, Country)
6. Date of Death (Month, Day, Year)
7. Time of Death (Hour, Minute)
8. Cause of Death (Print or Write)
9. Manner of Death (Print or Write)
10. Signature of Physician (Print or Write)
11. Signature of Registrar (Print or Write)
12. Signature of Coroner (Print or Write)
13. Signature of Medical Examiner (Print or Write)
14. Signature of Health Officer (Print or Write)
15. Signature of Other (Print or Write)
16. Signature of Other (Print or Write)
17. Signature of Other (Print or Write)
18. Signature of Other (Print or Write)
19. Signature of Other (Print or Write)
20. Signature of Other (Print or Write)
21. Signature of Other (Print or Write)
22. Signature of Other (Print or Write)
23. Signature of Other (Print or Write)
24. Signature of Other (Print or Write)
25. Signature of Other (Print or Write)
26. Signature of Other (Print or Write)
27. Signature of Other (Print or Write)
28. Signature of Other (Print or Write)

3811

CERTIFICATE OF DEATH

03781

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>3512 Frederick Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>BERTHA E. SCHEVERMANN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1864</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Residence</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>CHARLES C. SCHEVERMANN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA E. WENDEROTH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Miss. EDNA M. McALLISTER</u>	
		Address <u>3512 Frederick Ave.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V.D.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____

21. I certify that I attended the deceased from <u>Jan. 1944</u> , to <u>April 30, 1956</u> , that I last saw the deceased alive on <u>April 30, 1956</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>J. C. Pound</u>	DATE SIGNED <u>5/2/56</u>
PHYSICIAN'S NAME (Type) <u>J. C. Pound</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>MAY 3-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Truman Schwal</u>		24a. REC'D BY REGISTRAR <u>3512 Frederick Ave.</u>	24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3812 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	BALTIMORE	STATE	MD. COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL OR and give nearest town)	ROSEDALE	CITY (If outside corporate limits, write RURAL and give nearest town)	ROSEDALE
HOSPITAL OR INSTITUTION OR STREET ADDRESS	7925 Dalrose Ave.	STREET ADDRESS	7925 DALROSE AVE.
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	EDWARD	(Middle)	GEORGE
(Last)	SCHMAUS	OF DEATH:	April 2 1956.
5. SEX:	Male	6. COLOR OR RACE:	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	Married	8. DATE OF BIRTH:	Jan. 29, 1891.
9. AGE last birthday	65 yrs.	IF UNDER 1 YEAR	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
Retired		Glass Business	Baltimore, Md.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
JOHN SCHMAUS		ANNA FUHRER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)		17. INFORMANT & ADDRESS:	
NO		Elizabeth Schmaus Same.	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE		(A) Hypertensive Cardio Vascular Disease.	
ANTECEDENT CAUSE (S)		DUE TO Pulmonary atherosclerosis.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(B) Atherosclerosis	
		(C) Cerebral Thrombosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 15, 1956, to April 1, 1956, that I last saw the deceased alive on April 1, 1956, and that death occurred at 8:55 AM from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Michael J. Janowski		4/4/56	
M. D.		2711 Eastern Ave.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
BURIAL		4-5-56 SACRED HEART CEM. 7401 GERMAN HILL RD., MD.	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
April 4, 1956		Charles A. Giller 901 S. CONKLING ST. BALTO., MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr Jamieson
2711 Eastern
Ave -

3813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>60 Dogwood Drive</u>				d. STREET ADDRESS <u>60 Dogwood Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>ORRIE</u> Middle <u>E.</u> Last <u>SEARS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1882</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Beaugard Sears</u>				14. MOTHER'S MAIDEN NAME <u>Lillian B. Trott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-01-5462</u>		17. INFORMANT <u>Clara N. Shipley, 60 Dogwood Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490X Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Hemiplegia--right - obesity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>10 Yrs.</u> <u>10 Yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 19, 1956</u> to <u>April 29, 1956</u> , that I last saw the deceased alive on <u>April 29, 1956</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>413 Eastern Avenue</u> DATE SIGNED <u>April 30, 1956</u>							
ACTUAL SIGNATURE <u>Harry B. Smith</u>				M.D. <u>Baltimore 21, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Harry B. Smith, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/2/56</u>		22c. NAME OF CEMETERY <u>Baldwin Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Severn Crossroads, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc</u>				ADDRESS <u>1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>5/2/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Edith Shirley</u>			

MEDICAL CERTIFICATION

Mr. J. H. 1212 St. Paul Street

RECEIVED

MAY 2 1956

BUREAU V. S.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03784

Reg. Dist. No. 38

3814

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 Bosley Ave.				STREET ADDRESS (If rural give location) 500 Bosley Ave.			
3. NAME OF DECEASED (Type or Print) CHARLES (First) WILSON (Middle) SHADE (Last)				4. DATE OF DEATH (Month) (Day) (Year) April 23, 1956			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 5, 1893		9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Meat Packers		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Shade				14. MOTHER'S MAIDEN NAME Mary Fetter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Laura Shade-500 Bosley Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
016X IMMEDIATE CAUSE (A)				UREMIC POISONING		3/56	
ANTECEDENT CAUSE(S) DUE TO				The psychosis & nephritis		1952	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1949, 19, to 4/23, 1956, that I last saw the deceased alive on 4/23, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE <i>W. Karlam</i>		M.D. <i>4331 Haywood Rd</i>		ADDRESS (Street, city, town, state)		DATE SIGNED <i>4/25/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 4/27/56		NAME OF CEMETERY OR CREMATORY Green Mount Crematory		LOCATION (City, town, or county) (State) Balto., Md.	
24. REC'D BY REGISTRAR APR 25 1956		REGISTRAR'S SIGNATURE <i>Mabel Gray</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tiekner & Sons</i>		ADDRESS <i>Balto Md</i>	

CERTIFICATE OF DEATH

9314

LOCAL HEALTH DEPARTMENT - NUMBER OF DEATHS

STATE DEPARTMENT OF HEALTH - NUMBER OF DEATHS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

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CAUSE OF DEATH

PLACE OF BIRTH

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RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

BUREAU M.B.

APR 26 1956

RECEIVED

IN REGISTRATION OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD
 This is a true and correct copy of the original of the above certificate of death as filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, on the 26th day of April, 1956.
 REGISTERED

3661

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 53 TOWN Dundalk		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 53 TOWN Dundalk			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 Baltimore Ave. 00				STREET ADDRESS (If rural give location) 100 Baltimore Ave.			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		CONRAD HENRY SHANAWOLF		April 21		19 56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	Married	March 26, 1880	76	Yrs.	Months	Days
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Salesman		Jewelery		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
? Shanawolf				Christina ?			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
Yes		E A W		Mrs. Herman Auvil 3469 Dunhaven Road-22			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.1 Immediate cause (a) Coronary Occlusion						30 min.	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio Sclerotic H.D.						10 yrs.	
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ?				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
m.							
22. I hereby certify that I attended the deceased from 1956 to 4-21-56, that I last saw the deceased alive on 4-10-56, and that death occurred at 2 PM, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Jack E. Callahan, M.D.		April 24, 1956		Parkwood Cemetery		Parkville, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
April 24-1956		William M Kelly		Ullrich Funeral Home		2112 Dundalk Ave.	

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

General Counsel
After 11:10

30 min
10:45

BUREAU V. 1

APR 26 1956

RECEIVED

4-21

3:45

1

4-10 15

John E. Williams, M.D.

2 hours trip

1-54-55

CERTIFICATE OF DEATH

Reg. Dist. No.

30

3815

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklintown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklintown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1516 Saint Agnes Lane</u>				d. STREET ADDRESS <u>1516 Saint Agnes Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Freda</u> Middle <u>R.</u> Last <u>Sieck</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22, 1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. County Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frederick Reitz</u>				14. MOTHER'S MAIDEN NAME <u>Helen Mahlman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr A. Fred Sieck, 1516 St Agnes Lane.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Hypertensive Heart disease</u> DUE TO <u>Cardio-vascular - renal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 years</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>47</u> , to <u>4/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-13</u> , 19 <u>56</u> , and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Scheve</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>H. W. SCHEVE, M. D.</u>				<u>3921 EDMONDSON AVE.</u> <u>BALTIMORE 29, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Violetville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harriet H. Witke</u> ADDRESS <u>101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR <u>DATE 22 18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2018

BUREAU V. S.

APR 18 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use extra copies of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

3816 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loch Raven Reservoir		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		d. STREET ADDRESS 5508 Lombardy Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VINCENT Middle M Last SISK		4. DATE OF DEATH Month 4 Day 27 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 4 Days 27 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Baltimore & Ohio R.R.	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Sisk		14. MOTHER'S MAIDEN NAME Elizabeth Crowley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Henry F. Ullrich		Address 5508 Lombardy Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING, FOUND DROWNED 929.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) --- (c) --- DUE TO (a), stating the underlying cause last. (c) ---		INTERVAL BETWEEN ONSET AND DEATH ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ---		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PAUL F. GUERIN		DATE SIGNED 4-28-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/56	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Weaver Son 805 N Calvert St.		24a. REC'D BY REGISTRAR April 28 1956 R. W. Mabel Gray	
24b. REGISTRAR'S SIGNATURE ---			

RECEIVED
APR 30 1956
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03788

3817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 26 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) 50 Veterans Administration Hospital				d. STREET ADDRESS 4040 Edgewood Road			
3. NAME OF DECEASED (Type or print) First Middle Last DAVID (DANIEL SULLIVAN) D. SMULLIAN IVAN				4. DATE OF DEATH Month Day Year April 27 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1893		9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Racing Association		11. BIRTHPLACE (State or foreign country) Waterford, Ireland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Sullivan				14. MOTHER'S MAIDEN NAME Reba Jacobson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-03-1615		17. INFORMANT Address Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 422.1 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						INTERVAL BETWEEN ONSET AND DEATH 2 HOURS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1 , 19 56 , to April 27 , 19 56 , that I last saw the deceased alive on April 27 , 19 56 , and that death occurred at 7:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND 4/27/56							
ACTUAL SIGNATURE Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/27/56							
PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-56		22c. NAME OF CEMETERY OR CREMATORY Hebrew Rosedale Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. Inc. ADDRESS Md.				24. REGISTRAR'S SIGNATURE Dawson L. Laker			
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. Inc. ADDRESS Md.				24. REGISTRAR'S SIGNATURE Dawson L. Laker			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. S.

APR 30 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03789

3818 CERTIFICATE OF DEATH

Item 5: Tickner's statement 4-25-56L

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Balto.		MARYLAND		STATE Va.		COUNTY ✓	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN				TOWN Tye River		72x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Shaffer's Con. Retreat Columbia Pike RFD 29				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
CHARLIE WALKER SPENCER				April 16, 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	white	widowed	Nov. 7, 1879	76 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Car Repairman			Railroad		Va.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter Spencer				Wallie Boland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		719-03-8244		Mr. William Fogle-4514 Dunland Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A)				Cerebral thrombosis			
ANTECEDENT CAUSE(S) DUE TO				Arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Hemiplegia			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 20, 1956, to April 16, 1956, that I last saw the deceased alive on April 16, 1956, and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Louis R. Mason M.D.				4335 Park Heights Ave. Baltimore 4-1756			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		4/18/56		Amherst Cem.		Amherst, Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
APR 18 1956		W. E. Harty		Wm. J. Tickner & Sons - Balt.		17	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

FILE NO.

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

SIGNATURE OF REGISTRAR

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

1

2

3

4

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BUREAU V. 2

APR 18 1956

RECEIVED

3819

CERTIFICATE OF DEATH

Reg. Dist. No. 38

I. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Rural: Towson

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium
Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md

COUNTY Balto

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson.

STREET ADDRESS (If rural give location)

Eudowood San.

3. NAME OF DECEASED:

(First)

Annie

(Middle)

F

(Last)

Starr

4. DATE OF DEATH:

(Month)

4

(Day)

9

(Year)

1956

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

8. DATE OF BIRTH:

2/25/1887

9. AGE last birthday:

69 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Home.

11. BIRTHPLACE (State or foreign country):

Mathews Co, Va

12. CITIZEN OF WHAT COUNTRY:

U.S.

13. FATHER'S NAME:

James Owens

14. MOTHER'S MAIDEN NAME:

Dolly Sadler.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Personal History
Hospital Records, Eudowood Sanatorium

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X
Immediate cause

(a)

DUE TO

Cardiac Failure.

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

Emboli, Rtheg & Arter.

(c)

DUE TO

Pulmonary Tuberculosis.

Interval Between Onset And Death

6 mos.

3 1/2 mos.

6 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/3 1955 to 4/9 56, that I last saw the deceased

alive on 4/9 56, and that death occurred at 7:30 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

9 M. B. K. M. D. Eudowood Sanatorium - Towson 4, Maryland

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
2601-3-5 E. Madison St.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE STATE OF NEW YORK
IN SENATE
January 10, 1901.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1899.

THE STATE OF NEW YORK
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January 10, 1901.

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IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.

ALBANY:
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PRINTERS,
1899.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film 915 1-12-56 st
3820 Item 2, Film 915 1-10-56 st
CERTIFICATE OF DEATH

03791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 602 Careysbrook Road	
3. NAME OF DECEASED (Type or print) Edward Leo Starr		4. DATE OF DEATH Month April Day 6 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10, 1887
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		11b. KIND OF BUSINESS OR INDUSTRY Retired	
11c. BIRTHPLACE (State or foreign country) Maryland		11d. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Starr		14. MOTHER'S MAIDEN NAME Cathrine Hyland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-34-3550	
17. INFORMANT James R. Athon		Address Pikesville 602 Careysbrook Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis CVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH about 2 wks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from about , 19 54 , to April 6 , 19 56 , that I last saw the deceased alive on April 5 , 19 56 , and that death occurred at 11 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Hightsten		ADDRESS (Street, city or town, state) 888 W. Lombard St	
PHYSICIAN'S NAME (Type) G. HIGHTSTEN M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR DATE 10 10 1956	
24b. REGISTRAR'S SIGNATURE Dorothy Newell			

APR 10 1956

RECEIVED

3821

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2806 Glendale Avenue				d. STREET ADDRESS 2806 Glendale Avenue			
3. NAME OF DECEASED (Type or print) Mrs. Anna M. Steiner				4. DATE OF DEATH 4/22/1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1868	
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ferdinand Salzman				14. MOTHER'S MAIDEN NAME Elinor Fritzenwanken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Earl Rullman, 2806 Glendale Avenue #14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 9 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-23- , 1947, to 4-22- , 1956, that I last saw the deceased alive on 4-22- , 1956, and that death occurred at 940 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Milton C. Rany M.D.				ADDRESS (Street, city or town, state) 2117 Belair Rd DATE SIGNED 4-24-56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/1956		22c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Marford Road #14				24a. REC'D BY REGISTRAR DATE 4/26/56		24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

NAME OF DECEASED		DATE OF DEATH	
TALBOT, JAMES		JAN 10 1955	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
AGE		SEX	
65		M	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		DATE OF INTERMENT	
NATURAL		JAN 15 1955	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES TALBOT		JAMES TALBOT	
ADDRESS		CITY	
1234 BALTIMORE AVE		BALTIMORE, MD	
STATE		COUNTY	
MD		BALTIMORE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF MINISTER	
JAMES TALBOT		JAMES TALBOT	
ADDRESS		CITY	
1234 BALTIMORE AVE		BALTIMORE, MD	
STATE		COUNTY	
MD		BALTIMORE	

BUREAU V. S.

APR 27 1956

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
TALBOT, JAMES		JAN 10 1955	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
AGE		SEX	
65		M	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		DATE OF INTERMENT	
NATURAL		JAN 15 1955	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES TALBOT		JAMES TALBOT	
ADDRESS		CITY	
1234 BALTIMORE AVE		BALTIMORE, MD	
STATE		COUNTY	
MD		BALTIMORE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03793

CERTIFICATE OF DEATH

Reg. Dist. No.

3822

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville 38 Md				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) 14 Spring Grove State Hospital				d. STREET ADDRESS 6810 Dogwood Road			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward Strong				4. DATE OF DEATH Month Day Year April 1, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 3, 1903	9. AGE (In years lost birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James E. Strong				14. MOTHER'S MAIDEN NAME Annie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO.			
17. INFORMANT Records: Spring Grove State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia, infarctive 026X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) C.N.S. Les DUE TO (c) years							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Mar. 12, 19 56 to Apr. 1, 19 56 that I last saw the deceased alive on Mar. 31, 19 56 , and that death occurred at 2:45A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE T. Glyne Williams				M.D. Spring Grove State Hospital		DATE SIGNED 4/7/56	
PHYSICIAN'S NAME (Type) T. Glyne Williams, M.D.				ADDRESS (Street, city or town, state) Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/1956		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Worth Amason				ADDRESS 4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR APR 3 1956	
				24b. REGISTRAR'S SIGNATURE T. E. Thoms			

RECEIVED

BUREAU V. S.

APR 3 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3662

CERTIFICATE OF DEATH

Reg. Dist. No. 03794

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u> c. LENGTH OF STAY IN 1b <u>53</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3124 Sollers Point Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>3124 Sollers Point Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>MARY</u> Last <u>SUMMERS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>19 56</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1884</u>		9. AGE (In years lost birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Katlack</u>				14. MOTHER'S MAIDEN NAME <u>---</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Carroll L. Strupp - 1911 Griffin Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart des.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-11</u> , 19 <u>56</u> , to <u>4-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-30</u> , 19 <u>56</u> , and that death occurred at <u>21</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.				ADDRESS (Street, city or town, state) <u>2 Kinship Road Baltimore 22, Maryland</u>				DATE SIGNED <u>4-1-56</u>	
PHYSICIAN'S NAME (Type) <u>Jack C. Collins M.D.</u>				22. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) <u>Balto., Md.</u>		22e. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto.</u>				ADDRESS <u>Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. P. Kelly</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

15

BUREAU V. 3

MAY 3 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03795

3653 CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 9 Film 6195 4-16-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>2 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7903 ST. GREGORY DRIVE</u>				STREET ADDRESS (If rural give location) <u>7903 ST. GREGORY DRIVE</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARK HAMMELL TABLER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APR. 9 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug 22, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NELSON TABLER</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE HICKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-10-9573</u>		17. INFORMANT & ADDRESS <u>MYRTLE A. TABLER - SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						7-2 hours	
443X IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Asthma and Emphysema</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 23, 1956</u> , to <u>April 9, 1957</u> , that I last saw the deceased alive on <u>April 4, 1957</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ravil Owens</u>				ADDRESS (Street, city, town, state) <u>914 D St. 136 170. 19 Md.</u>		DATE SIGNED <u>APR 11 1957</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-12-57</u>		NAME OF CEMETERY OR CREMATORY <u>ROSEDALE</u>		LOCATION (City, town, or county) (State) <u>MARTINSBURG, W. VA.</u>	
24. REC'D BY REGISTRAR <u>APR 11 1957</u>		REGISTRAR'S SIGNATURE <u>Don Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Ruth Hodges</u>		ADDRESS <u>144</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

17. SIGNATURE OF

18. SIGNATURE OF

19. SIGNATURE OF

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28. SIGNATURE OF

29. SIGNATURE OF

30. SIGNATURE OF

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

17. SIGNATURE OF

18. SIGNATURE OF

19. SIGNATURE OF

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NOTARIZATION
I, the undersigned, a Notary Public for the State of Maryland, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health of the State of Maryland.

BUREAU V. S.

APR 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3823

CERTIFICATE OF DEATH

03796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Larchmont				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Larchmont			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2604 Poplar Drive				d. STREET ADDRESS 2604 Poplar Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FANNIE Middle AMELIA Last TAYLOR				4. DATE OF DEATH Month Apr. Day 25 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1873		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Jordon				14. MOTHER'S MAIDEN NAME Rhoda Rumsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Charles H. Taylor - 2604 Poplar Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer - diffuse 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 16th, 1955 , to April 25, 1956 , that I last saw the deceased alive on April 25th, 1956 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 37 W. Preston Street DATE SIGNED							
ACTUAL SIGNATURE Dr. Harry D. M'Learty M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/56		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons, Balto. Md.				24a. REC'D BY REGISTRAR 1 1956		24b. REGISTRAR'S SIGNATURE Dr. Th. E. Martin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 I AV.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03797

Reg. Dist. No. 38

3824

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3025 Linwood Avenue #14				d. STREET ADDRESS 3025 Linwood Avenue			
3. NAME OF DECEASED (Type or print) MARY MARGARET TAYLOR				4. DATE OF DEATH Month APRIL 1st 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1885	
9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Clara (Unknown)				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Emma Mc Kean, 4921 Denmore Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - Hypertensive 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardio-vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 2/25 , 19 55 , to Jan 28 , 19 56 , that I last saw the deceased alive on 1/28 , 19 56 , and that death occurred at 14510 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Nathan Janney M.D.				ADDRESS (Street, city or town, state) 7101 Harford Rd. Balto. 14, Md.			
PHYSICIAN'S NAME (Type) Nathan Janney				DATE SIGNED 4/2/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/1956		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14				24a. REC'D BY REGISTRAR DATE Apr. 3, 1956			
24b. REGISTRAR'S SIGNATURE Dr. D. M. Bacon							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. HARRIS		2. SEX Male	
3. AGE 35		4. OCCUPATION Carpenter	
5. PLACE OF BIRTH Maryland		6. DATE OF BIRTH Nov. 1, 1903	
7. PLACE OF DEATH Baltimore, Maryland		8. DATE OF DEATH Nov. 1, 1938	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF PHYSICIAN J. M. Harris		12. SIGNATURE OF WITNESSES J. M. Harris	
13. SIGNATURE OF REGISTRAR J. M. Harris		14. SIGNATURE OF CLERK J. M. Harris	

RECEIVED
APR - 4 1938
BUREAU Y. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3672 CERTIFICATE OF DEATH

03798

Reg. Dist. No. 47

1. PLACE OF DEATH <i>Baltimore County</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>MARYLAND</i>		MARYLAND		STATE <i>MARYLAND</i> COUNTY <i>Balto.</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Arbutus</i>		<i>64 yrs.</i>		TOWN <i>BALTO. or ARBUTUS</i>		<i>51</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Residence - Locust Ave.</i>				STREET ADDRESS (If rural give location) <i>Locust Ave.</i>			
3. NAME OF DECEASED (Type or Print) <i>Marie Adelaide Teipe</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>April 18, 1956</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>JAN. 24, 1892</i>	9. AGE last birthday <i>64</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
						Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BILLING CLERK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>VA. CAROLINA CO.</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John A. Teipe</i>				14. MOTHER'S MAIDEN NAME <i>Isabelle A. Gocking</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-07-9043</i>		17. INFORMANT & ADDRESS <i>Locust Ave. Miss. CLARA S. Teipe (27)</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1999 IMMEDIATE CAUSE (A) <i>Carcinoma - origin unknown</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>with multiple metastases -</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Pathologic fracture right thigh</i>				<i>Jan 27-56</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1908</i> , to <i>April 18, 1956</i> , that I last saw the deceased alive on <i>April 18th</i> , 19 <i>56</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Fredrick V. Beeter</i>				ADDRESS (Street, city, town, state) <i>M.D. 1014 Francis Ave - Balto 27 - Md.</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4-21-1956</i>		NAME OF CEMETERY OR CREMATORY <i>New CATHEDRAL CEM. BALTO. Md.</i>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Dr. Geo. J. M. Luffey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>G. Therman Schuch</i>		ADDRESS <i>3512 Fredrick Ave. (29)</i>	

APR 20 1956

BUREAU V. S.

APR 20 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03799

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3825

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 13, 14 Film G198 5-31-56 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SPACCAWS POINT</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATON RIDGE HOME</u>		STREET ADDRESS <u>306 D ST.</u> (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>SARAH F. THOMAS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4 26 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.H.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>5/20/1886</u>
9. AGE last birthday <u>69</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-28-0665</u>	
17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>			<u>2 hrs</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis gen</u>			<u>unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gastric Disturbance 7 abd</u>			<u>48 hrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/26</u> 19<u>56</u>, to <u>4/27</u> 19<u>56</u>, that I last saw the deceased alive on <u>4/26</u> 19<u>56</u>, and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Cory Rounts J.</u>		ADDRESS (Street, city, town, state) <u>4605 Edmond Ave</u>	
		DATE SIGNED <u>4/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-28-56</u>	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>		LOCATION (City, town, or county) <u>Bolts. MD</u>	
DATE <u>APR 30 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Burke Bradley, Bethesda, Md</u>	
		ADDRESS	

CERTIFICATE OF DEATH

REG-001-1-1

1. NAME OF DECEASED (Last, first, middle initial)

MARYLAND

COUNTY OF

DATE

TIME

PLACE

CAUSE

MANNER

DOCTOR

DEATH

2. MEDICAL CERTIFICATION

MD-11-0002

BUREAU V. S.

APR 30 1956

RECEIVED

1127500221

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3826

CERTIFICATE OF DEATH

Reg. Dist. No.

03800

45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTO		MARYLAND		STATE MD		COUNTY BALTO	
CITY (If outside corporate limits, write RURAL OR and give nearest town) ESSEX (21)		LENGTH OF STAY (in this place) 6 WK.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DUNDALK (22)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 114 HALL HOME				STREET ADDRESS (If rural give location) 7829 WISE AVE			
3. NAME OF DECEASED: (First) (Middle) (Last) NAOMI BURROWS TITUS				4. DATE (Month) (Day) (Year) OF DEATH: 4-16-1956			
5. SEX: F.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: FEB. 6, 1885	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: LEVI BURROWS				14. MOTHER'S MAIDEN NAME: SARAH JANE WRIGHT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-24-7869		17. INFORMANT & ADDRESS: JESSE L. TITUS - SAME	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of gall bladder						6 months	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION Carcinoma of gall bladder			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 19, 1956 to April 16, 1956 that I last saw the deceased alive on April 12, 1956 , and that death occurred at 11 53 A.M. from the causes and on the date stated above.							
SIGNATURE A. L. Kolodny MD				ADDRESS Baltimore 21, Md		DATE SIGNED 4/16/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-20-56		NAME OF CEMETERY OR CREMATORY MEADONRIDGE		LOCATION (City, town, or county) (State) HOWARD Co. MD.	
DATE REC'D BY LOCAL REGISTRAR April 20, 1956		REGISTRAR'S SIGNATURE Mrs. Edith Hurley		24. FUNERAL DIRECTOR Walter Burke Brady, Huntley, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 23 1956

RECEIVED

JAN 23 1956
RECEIVED
U.S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03801

3827

CERTIFICATE OF DEATH

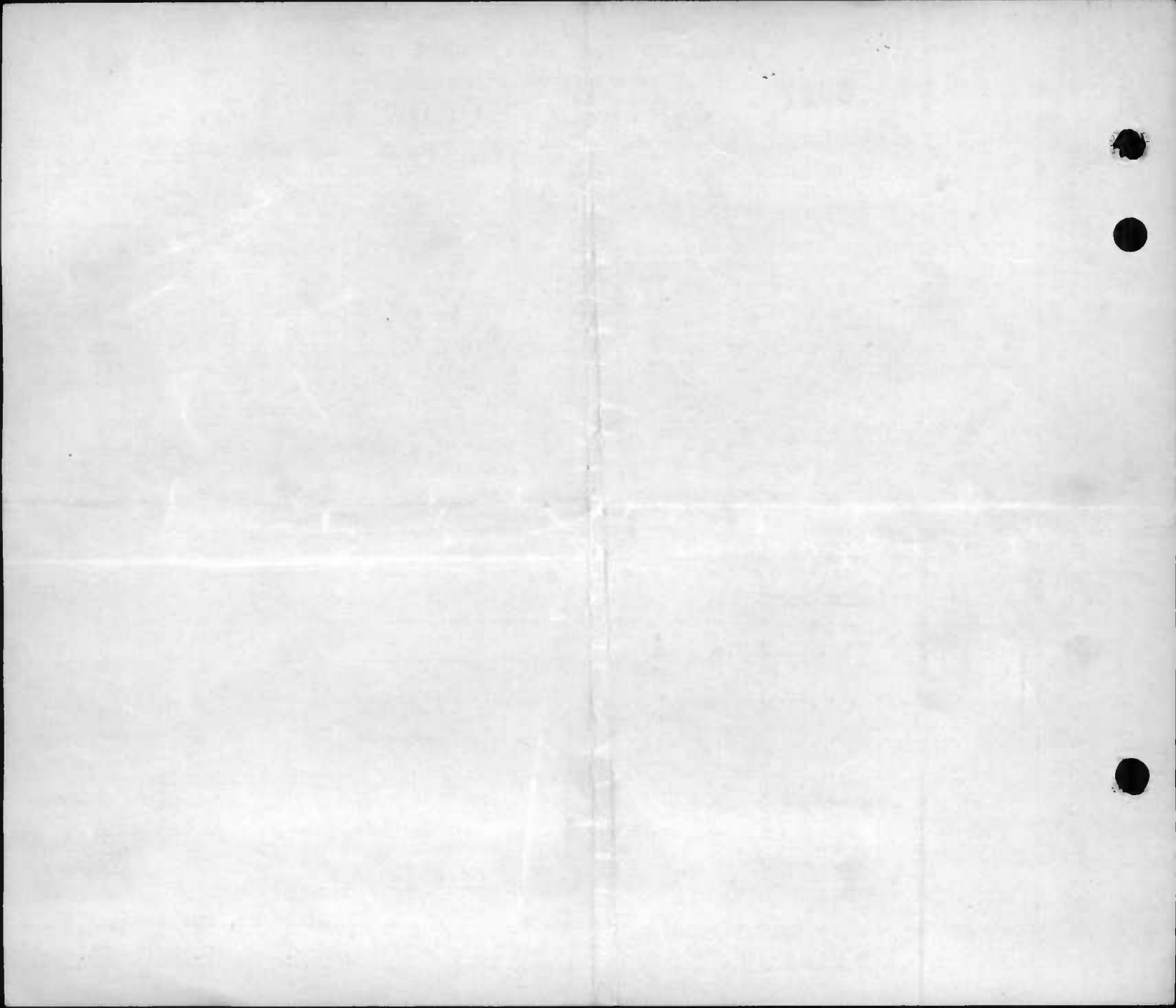
Reg. Dist. No.

Item 2, Film G196 4-23-56 et

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Lutherville		LENGTH OF STAY (in this place) 2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Lutherville		Baltimore 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS College Manor				STREET ADDRESS (If rural, give location) College Manor		3516 Erdman Ave.	
3. NAME OF DECEASED (First) Anna		(Middle) K.		(Last) Tochterman		4. DATE OF DEATH (Month) April (Day) 11 (Year) 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH July 11, 1888	9. AGE last birthday 67 yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Fries		14. MOTHER'S MAIDEN NAME Mary Sutter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Edward S. Tochterman 3516 Erdman Ave.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
334X Immediate cause (a) Coronary artery disease Cerebral arteriosclerosis						3 yrs	
Antecedent cause(s) (b) Chronic bronchitis, emphysema						4 yrs	
(c) Malnutrition						months	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 8, 1954, to April 11, 1956, that I last saw the deceased alive on April 11, 1956, and that death occurred at 7:30 P.m., from the causes and on the date stated above.							
SIGNATURE Ernest C. Brown Jr.		(Degree or title) M.D.		ADDRESS 401 N. Calvert St.		DATE SIGNED 4/13/56	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF April 14, 1956		NAME OF CEMETERY OR CREMATORY Oak Lawn		LOCATION (City, town, or county) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. April 14, 1956		REGISTRAR'S SIGNATURE R. W.		24. FUNERAL DIRECTOR Lilly & Zeiler Inc.,		ADDRESS 403 S. Wolfe St.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3828

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>144 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1301 St. Paul Street</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>S.</u> Last <u>TUDOR</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1896</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment House</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward W. Tudor</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I 212-14-1568</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA OF TONGUE</u> <u>141X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>December 2, 1955</u> , to <u>April 24</u> , 19 <u>56</u> , and that death occurred at <u>3:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Francis G. Dickey</u> M.D. <u>4/24/56</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY, Chief Medical Service, VAH, FORT HOWARD, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u> <u>Wm Cook-Blight, Inc., 6009 Harford Rd., Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>APR 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Lister</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.
 APR 27 1956

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NATURAL	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF DEATH REGISTRAR _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF DEATH REGISTRAR _____	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3673

CERTIFICATE OF DEATH

03803

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Arbutus		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Arbutus			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5532 Link Ave.				STREET ADDRESS (If rural give location) 5532 Link Ave.			
3. NAME OF DECEASED (First) (Middle) (Last) EDYTHE TURNER				4. DATE OF DEATH (Month) (Day) (Year) April 3, 1956			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Dec. 10, 1888		9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Dennis				14. MOTHER'S MAIDEN NAME Caroline P. Hellen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr. Albert E. Lurner-5532 Link Ave. Arbutus, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Hypertensive CVD							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/1, 1956, to 4/3, 1956, that I last saw the deceased alive on 4/3, 1956, and that death occurred at 7:08 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Robert J. Lurichas</i>				ADDRESS (Street, city, town, state) 5305 East Drive Arbutus			
DATE SIGNED 4/5/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/6/56		NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Balto., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Dr. Geo. J. M. Luff</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner & Sons - Balt. Md.</i>			
DATE APR 6 1956							

CERTIFICATE OF DEATH

1953

File No.

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Date of burial

9. Place of burial

10. Signature of physician

11. Signature of registrar

12. Signature of medical examiner

13. Signature of coroner

14. Date of filing

15. Name of registrar

16. Name of medical examiner

BUREAU V. S.

APR 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G196 5-2-56 et

3829

CERTIFICATE OF DEATH

03804

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Riderwood Maryland				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Sorenson Nursing Home				d. STREET ADDRESS 7912 Rutway Rd. unknown			
3. NAME OF DECEASED (Type or print) First Edwin Middle M. Last Walker				4. DATE OF DEATH Month April Day 25 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1866	
9. AGE (In years lost birthday) yrs. 90		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Albert Walker -328 Rossiter Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis chronic with weakening DUE TO (c) Hypertrophy myocardium with failure						INTERVAL BETWEEN ONSET AND DEATH 30 minutes 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no injury				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no injury		20f. (City or town) (County) (State) no injury	
21. I certify that I attended the deceased from February 7, 1956 , to April 25, 1956 , that I last saw the deceased alive on April 17, 1956 , and that death occurred at 3.00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James Graham Marston, M.D.				ADDRESS (Street, city or town, state) 516 Cathedral Street Balto Md			
PHYSICIAN'S NAME (Type) James Graham Marston, M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF April 28, 1956		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemt. Balto. Md.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John A Moran				ADDRESS 3000 E Balto St.		24. REC'D BY REGISTRAR APR 30 1956	
				24b. REGISTRAR'S SIGNATURE Mabel Gray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

APR 30 1956

RECEIVED

3830

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 55 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS Dunkirk			
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last WALLACE				4. DATE OF DEATH Month April Day 30 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1920	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Tire man)				10b. KIND OF BUSINESS OR INDUSTRY (Air-craft) Government		11. BIRTHPLACE (State or foreign country) McKinley, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Wallace				14. MOTHER'S MAIDEN NAME Eliza MN: Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 214-16-1876		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FIBROSIS 420.1 DUE TO CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED SARCOIDOSIS							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from March 6, 1956 , to April 30, 1956 . I attended the deceased live or dead , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.				DATE SIGNED 5/1/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/56		22c. NAME OF CEMETERY OR CREMATORY Moses Cooper Cemetery		22d. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Johnson, 34 Lafayette Ave., Annapolis, Md.				24a. REC'D BY REGISTRAR DATE 5/2/56		24b. REGISTRAR'S SIGNATURE Lawson L. Lister	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

MAY 4 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03806

3831 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Balto.		STATE Md.		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Catonsville				TOWN Baltimore		3801-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 122 Smithwood Ave.				STREET ADDRESS (If rural give location) 2303 Riggs Ave.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) FRANCIS McDOWELL WARREN				4. DATE OF DEATH (Month) (Day) (Year) April 15, 1956			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Jan. 27, 1909	9. AGE last birthday 47 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Welding (Elec)		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John P. Warren				14. MOTHER'S MAIDEN NAME Mary Lankford Warren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Thelma Warren-2303 Riggs Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) CARCINOMATOSIS - GENERALIZED				INTERVAL BETWEEN ONSET AND DEATH 4 wks			
ANTECEDENT CAUSE(S) DUE TO (B) CARCINOMA - PANCREAS				3-4 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB 15, 1956, to APRIL 15, 1956, that I last saw the deceased alive on APRIL 15, 1956, and that death occurred at 1045P M, from the causes and on the date stated above.							
SIGNATURE Norman R. Kleiman M.D. 3803 Edmondson Ave				DATE SIGNED 4/17/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/18/56		NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		LOCATION (City, town, or county) Woodlawn, Md.	
24. REC'D BY REGISTRAR APR 18 1956		REGISTRAR'S SIGNATURE J. E. Harvey		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baltimore		ADDRESS	
DATE							

CERTIFICATE OF DEATH

REG. NO. 100

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

BUREAU V. S.

APR 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN 1b <u>16 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home, 3400 Hopkins Avenue</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>3400 Hopkins Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>Martha</u> Last <u>WEIDENHAMMER</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>19 56</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 9, 1915</u>		9. AGE (In years last birthday) <u>40 yrs.</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ADAM STRUMSKY</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET GREIFZU</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CHARLES WEIDENHAMMER 3400 Hopkins Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to hanging</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gunshot wound of left breast</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Hung self from rafter after shooting self.</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self from rafter after shooting self.</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Partial Halethorpe Balto. Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>						DATE SIGNED <u>4/19/56</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>				22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwalb</u>						ADDRESS <u>2101 Medfield Ave. Md.</u>		24a. REC'D BY REGISTRAR <u>APR 23 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Luff</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, giving the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

APR 23 1956

RECEIVED

William J. [Signature]

X

3832

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. NAME OF DECEASED (Type or Print) ERNEST PHILLIP WESTERLUND			2. DATE OF DEATH APRIL 3, 1956		
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTO. Co. MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 55 427 REGISTER AVE.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TOWSON 56		
c. Length of stay in Baltimore co. 27 YRS Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 427 REGISTER AVE.		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 1, 1889	9. AGE (In years last birthday) 66	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPT. CHIEF			10B. KIND OF BUSINESS OR INDUSTRY WESTERN ELECT.		
11. BIRTHPLACE (State or foreign country) CHICAGO ILL.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME CARL JOHAN WESTERLUND			14. MOTHER'S MAIDEN NAME ANNA CARLSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO			16. SOCIAL SECURITY NO. 215-03-9533		
17. INFORMANT MRS. ADELINE WESTERLUND			ADDRESS SPAIN		

18. 162X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchogenic Carcinoma		CAUSE OF DEATH 2 1/2 months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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210. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I certify that (I) (this hospital) attended the deceased from **23-January** 19**56** to **4-April** 19**56**, that (I) (we) last saw the deceased alive on **4-April** 19**56**, and that death occurred at **8:30 P.** m., from the causes and on the date stated above.

23A. SIGNATURE Charles W. Edmunds ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23B. ADDRESS 2746 The Alameda	23C. DATE SIGNED 5-April-1956
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24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-6-1956	24C. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.	24D. LOCATION (City, town, or county) (State) BALTO. Co. MD.
--	------------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR 10-6-1956	REGISTRAR'S SIGNATURE A.W. Hedrich	25. FUNERAL DIRECTOR H.W. JENKINS & SONS Co	ADDRESS 4905 York Rd
--	--	---	--------------------------------

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed with the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03809

3833

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. LENGTH OF STAY IN 1b 25 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2908 Erie Ave.		d. STREET ADDRESS 2908 Erie Ave.	
3. NAME OF DECEASED (Type or print) First Freda Middle O. Last Wiebking		4. DATE OF DEATH Month April Day 14 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1895
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Dornbusch		14. MOTHER'S MAIDEN NAME Mary Kuehnle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rev. Carl C. Wiebking-2908 Erie Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of uterus DUE TO (b) Generalized Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from ap 19 , 19 48 , to ap , 19 56 , that I last saw the deceased alive on ap 19 , 19 56 , and that death occurred at 3: A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8106 Harford Rd DATE SIGNED ACTUAL SIGNATURE Harold H Burns M.D. Harold H. Burns PHYSICIAN'S NAME (Type) Harold H. Burns			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-1956	
22c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran		22d. LOCATION (City, town, or county) (State) Parkville, Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR APR 10	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon	

CERTIFICATE OF DEATH

3883

BUREAU V. S.

APR 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03810
3834 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JONES CREEK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JONES CREEK</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7238 HUGHES AVE</u>				d. STREET ADDRESS <u>7238 HUGHES AVE</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTIE LEE WILLIAMS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 13 1956</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10. 1871</u>			
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>JOSHUA WARNER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA BIST</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MILDRED MAGERS 7238 HUGHES AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SENILITY</u> DUE TO (c) <u>INANITION</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Nov. 23. 1955</u> to <u>Apr. 13. 1956</u> , that I last saw the deceased alive on <u>Apr. 11. 1956</u> , and that death occurred at <u>8:00 P.</u> M., from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>6908 North Pt. Rd Baltimore - 19 - md</u>				DATE SIGNED <u>4/14/56</u>					
ACTUAL SIGNATURE <u>Louis N. Towlin</u>				M.D. <u>Louis N. Towlin</u>					
PHYSICIAN'S NAME (Type) <u>Louis N. Towlin</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHN CEMETERY WESTMINSTER, MARYLAND</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - 19 - md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Bright Inc</u>				ADDRESS <u>6009 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>APR 17 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>									

CERTIFICATE OF DEATH

3834

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-1-21	
5. PLACE OF BIRTH Memphis, Tenn.		6. OCCUPATION Minister	
7. MARITAL STATUS Single		8. CAUSE OF DEATH Suicide	
9. MANNER OF DEATH Homicide		10. PLACE OF DEATH Baltimore, Md.	
11. DATE OF DEATH 4-4-68		12. TIME OF DEATH 11:00 AM	
13. SIGNATURE OF DECEASED James Earl Ray		14. SIGNATURE OF WITNESS James Earl Ray	
15. SIGNATURE OF PHYSICIAN James Earl Ray		16. SIGNATURE OF CORONER James Earl Ray	
17. SIGNATURE OF JURY James Earl Ray		18. SIGNATURE OF JUDGE James Earl Ray	
19. SIGNATURE OF DISTRICT ATTORNEY James Earl Ray		20. SIGNATURE OF CLERK James Earl Ray	
21. SIGNATURE OF CHIEF OF POLICE James Earl Ray		22. SIGNATURE OF SHERIFF James Earl Ray	
23. SIGNATURE OF TOWNSHIP CLERK James Earl Ray		24. SIGNATURE OF COUNTY CLERK James Earl Ray	
25. SIGNATURE OF STATE CLERK James Earl Ray		26. SIGNATURE OF NATIONAL CLERK James Earl Ray	
27. SIGNATURE OF INTERNATIONAL CLERK James Earl Ray		28. SIGNATURE OF UNITED NATIONS CLERK James Earl Ray	
29. SIGNATURE OF WORLD CLERK James Earl Ray		30. SIGNATURE OF GALAXY CLERK James Earl Ray	
31. SIGNATURE OF UNIVERSE CLERK James Earl Ray		32. SIGNATURE OF COSMOS CLERK James Earl Ray	
33. SIGNATURE OF HEAVEN CLERK James Earl Ray		34. SIGNATURE OF EARTH CLERK James Earl Ray	
35. SIGNATURE OF WATER CLERK James Earl Ray		36. SIGNATURE OF FIRE CLERK James Earl Ray	
37. SIGNATURE OF AIR CLERK James Earl Ray		38. SIGNATURE OF SPACE CLERK James Earl Ray	
39. SIGNATURE OF TIME CLERK James Earl Ray		40. SIGNATURE OF SPACE-TIME CLERK James Earl Ray	
41. SIGNATURE OF MATTER CLERK James Earl Ray		42. SIGNATURE OF ENERGY CLERK James Earl Ray	
43. SIGNATURE OF FORCE CLERK James Earl Ray		44. SIGNATURE OF MOTION CLERK James Earl Ray	
45. SIGNATURE OF LIFE CLERK James Earl Ray		46. SIGNATURE OF DEATH CLERK James Earl Ray	
47. SIGNATURE OF REBIRTH CLERK James Earl Ray		48. SIGNATURE OF TRANSFORMATION CLERK James Earl Ray	
49. SIGNATURE OF EVOLUTION CLERK James Earl Ray		50. SIGNATURE OF CREATION CLERK James Earl Ray	
51. SIGNATURE OF DESTRUCTION CLERK James Earl Ray		52. SIGNATURE OF REDEMPTION CLERK James Earl Ray	
53. SIGNATURE OF SALVATION CLERK James Earl Ray		54. SIGNATURE OF DELIVERANCE CLERK James Earl Ray	
55. SIGNATURE OF LIBERATION CLERK James Earl Ray		56. SIGNATURE OF FREEDOM CLERK James Earl Ray	
57. SIGNATURE OF EMANCIPATION CLERK James Earl Ray		58. SIGNATURE OF RESCUANCE CLERK James Earl Ray	
59. SIGNATURE OF DELIVERANCE CLERK James Earl Ray		60. SIGNATURE OF SALVATION CLERK James Earl Ray	
61. SIGNATURE OF REDEMPTION CLERK James Earl Ray		62. SIGNATURE OF TRANSFORMATION CLERK James Earl Ray	
63. SIGNATURE OF EVOLUTION CLERK James Earl Ray		64. SIGNATURE OF CREATION CLERK James Earl Ray	
65. SIGNATURE OF DESTRUCTION CLERK James Earl Ray		66. SIGNATURE OF REDEMPTION CLERK James Earl Ray	
67. SIGNATURE OF SALVATION CLERK James Earl Ray		68. SIGNATURE OF DELIVERANCE CLERK James Earl Ray	
69. SIGNATURE OF LIBERATION CLERK James Earl Ray		70. SIGNATURE OF FREEDOM CLERK James Earl Ray	
71. SIGNATURE OF EMANCIPATION CLERK James Earl Ray		72. SIGNATURE OF RESCUANCE CLERK James Earl Ray	
73. SIGNATURE OF DELIVERANCE CLERK James Earl Ray		74. SIGNATURE OF SALVATION CLERK James Earl Ray	
75. SIGNATURE OF REDEMPTION CLERK James Earl Ray		76. SIGNATURE OF TRANSFORMATION CLERK James Earl Ray	
77. SIGNATURE OF EVOLUTION CLERK James Earl Ray		78. SIGNATURE OF CREATION CLERK James Earl Ray	
79. SIGNATURE OF DESTRUCTION CLERK James Earl Ray		80. SIGNATURE OF REDEMPTION CLERK James Earl Ray	
81. SIGNATURE OF SALVATION CLERK James Earl Ray		82. SIGNATURE OF DELIVERANCE CLERK James Earl Ray	
83. SIGNATURE OF LIBERATION CLERK James Earl Ray		84. SIGNATURE OF FREEDOM CLERK James Earl Ray	
85. SIGNATURE OF EMANCIPATION CLERK James Earl Ray		86. SIGNATURE OF RESCUANCE CLERK James Earl Ray	
87. SIGNATURE OF DELIVERANCE CLERK James Earl Ray		88. SIGNATURE OF SALVATION CLERK James Earl Ray	
89. SIGNATURE OF REDEMPTION CLERK James Earl Ray		90. SIGNATURE OF TRANSFORMATION CLERK James Earl Ray	
91. SIGNATURE OF EVOLUTION CLERK James Earl Ray		92. SIGNATURE OF CREATION CLERK James Earl Ray	
93. SIGNATURE OF DESTRUCTION CLERK James Earl Ray		94. SIGNATURE OF REDEMPTION CLERK James Earl Ray	
95. SIGNATURE OF SALVATION CLERK James Earl Ray		96. SIGNATURE OF DELIVERANCE CLERK James Earl Ray	
97. SIGNATURE OF LIBERATION CLERK James Earl Ray		98. SIGNATURE OF FREEDOM CLERK James Earl Ray	
99. SIGNATURE OF EMANCIPATION CLERK James Earl Ray		100. SIGNATURE OF RESCUANCE CLERK James Earl Ray	

RECEIVED
APR 17 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03811

3835

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mount Vista Rd.</u>				d. STREET ADDRESS <u>Mount Vista Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Willick</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1871</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurseryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Willick</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Knox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-0500</u>		17. INFORMANT <u>Edward G. Willick-Mount Vista Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEUKEMIA</u> 177X DUE TO <u>CARCINOMA PROSTATE GLAND</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 wks. 6 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 9, 1949</u> to <u>4/15, 1956</u> , that I last saw the deceased alive on <u>4/15, 1956</u> , and that death occurred at <u>6:03 P.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> MD.				ADDRESS (Street, city or town, state) <u>Fork Md.</u>		DATE SIGNED <u>4/17/56</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fork M. E.</u>		22d. LOCATION (City, town, or county) (State) <u>Fork Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>DR 19 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Hallett</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

32

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY OR TOWN	
COUNTY		STATE	
AGE		SEX	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH	
PARENTS		SPOUSE	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. 3

APR 19 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Page 1 should be executed by the funeral director. Page 2, and 3 to the funeral director. Page 4 should be executed by the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03812

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Balto MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY ST MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 10 h.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18x-2 ✓ St. George, s Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Spring Grove State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice M Middle Wilson Last				4. DATE OF DEATH Month 4 Day 13 Year 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Unknown Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Walsh				14. MOTHER'S MAIDEN NAME Alice M. Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchopneumonia (c) underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George S. M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-16-56	
EXAMINER'S NAME (Type) George S. M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4/18/56	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Geier Funeral Home				ADDRESS 3605-14 St NW Wash DC		24a. REC'D BY REGISTRAR DATE 4/18/56	
				24b. REGISTRAR'S SIGNATURE V E Harry			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3838

BUREAU V. 4

APR 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03813

2411 N. Charles Street, Baltimore

3664

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Turners Station		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Turners Station	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 Cherry Lane		STREET ADDRESS (If rural, give location) 111 Cherry Lane	
3. NAME OF DECEASED (Type or Print)	(First) SALLIE	(Middle)	(Last) WILSON
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 20, 1875
9. AGE last birthday 80 yrs.		10. BIRTHPLACE (State or foreign country) South Carolina	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ben Jackson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mrs Jaunita Mandy 111 Cherry Lane			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause	(a) Cerebral vascular accident	4 wks
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	1 yr.
	(c) arteriosclerosis	1 yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) HOMICIDE	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-20, 1956**, to **4-21, 1956**, that I last saw the deceased alive on **4-20, 1956**, and that death occurred at **10:50 a.m.**, from the causes and on the date stated above.

SIGNATURE **Harold Noble M.D.** (Degree or title) ADDRESS **7 South Lane** DATE SIGNED **April 21, 1956**

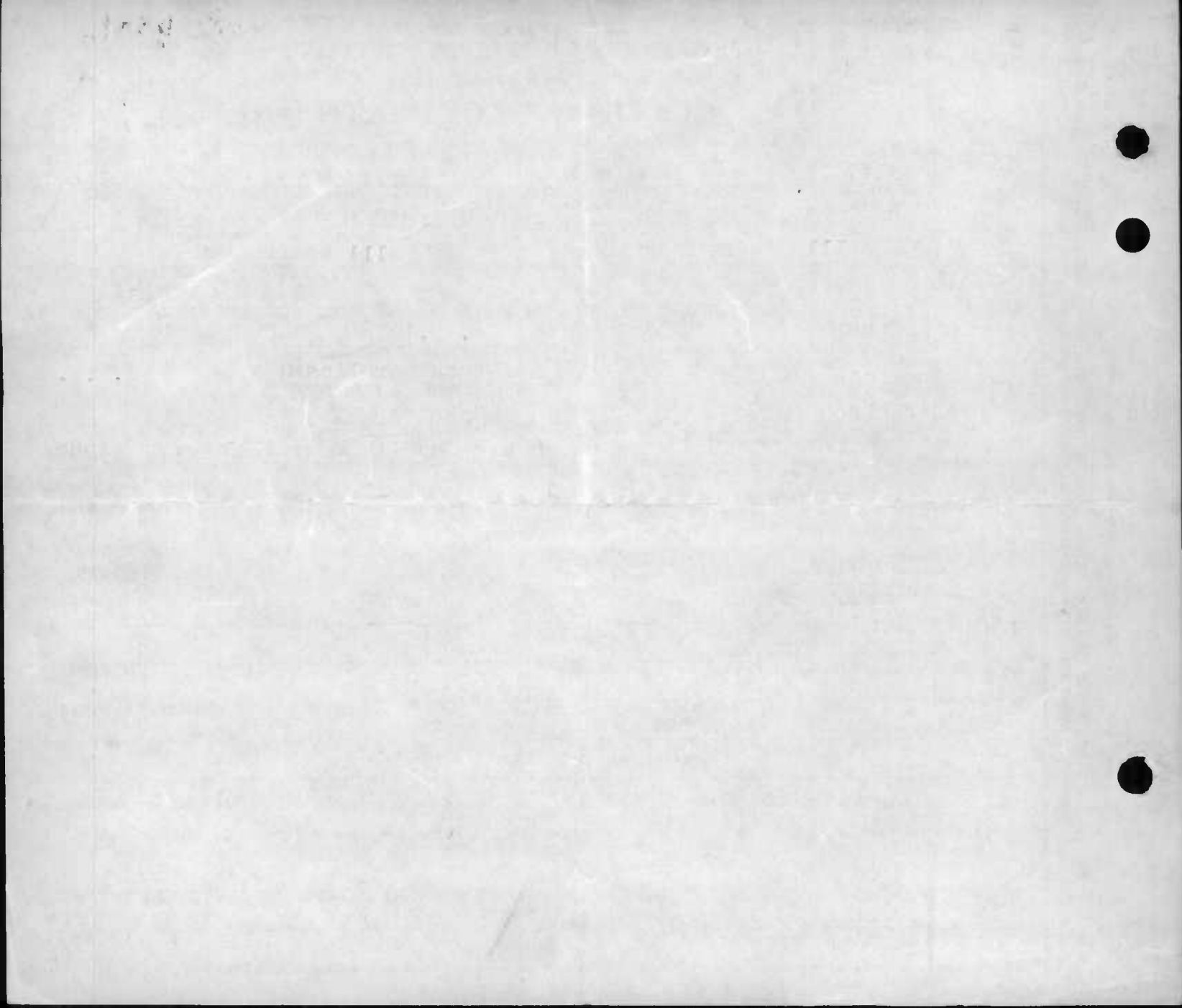
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 4-24-56	NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery	LOCATION (City, town, or county) Baltimore	(State) Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE A. M. Hedrick	FUNERAL DIRECTOR Mrs. Frances C. Henneley	ADDRESS Baltimore	

4-23-56

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Deputy Medical Examiner. The word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3665

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

038141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>S</u> b. COUNTY <u>ME</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AS ME</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2621 LIBERTY PKWY</u>				d. STREET ADDRESS <u>#1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>THOMAS</u> Last <u>YOWELL</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-27-1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY YOWELL</u>				14. MOTHER'S MAIDEN NAME <u>VIRG.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-701681</u>		17. INFORMANT <u>J.H. YOWELL - 2987 YORKWAY - DUNDALK</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>A-S-C-V Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>CHATESVILLE, PENNA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Bradley, Dundalk, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 25 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5205

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>	
<p>4. OCCUPATION</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF BIRTH</p>	
<p>7. PLACE OF DEATH</p>		<p>8. DATE OF DEATH</p>		<p>9. TIME OF DEATH</p>	
<p>10. CAUSE OF DEATH</p>		<p>11. MANNER OF DEATH</p>		<p>12. SIGNATURE OF EXAMINER</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF WITNESS</p>	
<p>16. SIGNATURE OF WITNESS</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF WITNESS</p>	
<p>19. SIGNATURE OF WITNESS</p>		<p>20. SIGNATURE OF WITNESS</p>		<p>21. SIGNATURE OF WITNESS</p>	
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RECEIVED
BUREAU V. S.
APR 25 1956

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